DOCUMENT RESUME

ED 451 016 RC 022 886

AUTHOR Dunbar, Jennifer L.; Sloane, Harvey I.; Mueller, Curt D.
TITLE Implementation of the State Children's Health Insurance Program: Outreach, Enrollment, and Provider Participation in Rural Areas.
INSTITUTION Project HOPE Walsh Center for Rural Health Analysis, Bethesda, MD.
SPONS AGENCY Health Resources and Services Administration (DHHS), Rockville, MD. Office of Rural Health Policy.
PUB DATE 1999-11-00
NOTE 70p.
CONTRACT CSURC0005-03
AVAILABLE FROM Full text at Web site: http://www.projecthope.org/CHA/pdf/schip99.pdf.
PUB TYPE Reports - Evaluative (142)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS American Indians; *Children; Economically Disadvantaged; Eligibility; *Enrollment; Health Insurance; *Outreach Programs; *Program Implementation; Recruitment; Rural Areas; *Rural Youth; *State Programs
IDENTIFIERS Access to Health Care; Barriers to Participation; *Childrens Health Insurance Program; Colorado; Kansas; Oklahoma; Pennsylvania; West Virginia

ABSTRACT

The state Children's Health Insurance Program (CHIP) funds state programs to help low-income, uninsured children overcome financial barriers to medical care. Previous research found that rural children were more likely to be uninsured than urban children. This report examines the implementation of CHIP and related outreach, enrollment, and provider issues in selected rural areas of Colorado, Kansas, Oklahoma, Pennsylvania, and West Virginia. Chapter 1 describes the federal legislation creating the program, additional private financial support for the program, selection of study states and rural areas, and research questions and methods. Chapter 2 discusses common enrollment issues: clarification of "public charge" rules for immigrants, CHIP and the Indian Health Service, welfare reform connections, and the 10 percent limit on administrative expenditures. Chapters 3-7 examine age and income eligibility criteria; specific rural outreach strategies, including outreach to Native Americans and limited-English-speaking populations; barriers to outreach; enrollment; and provider issues in each of the five states. Results indicate that the states are implementing rural outreach and enrollment activities more aggressively under CHIP than under previous children's insurance plans. CHIP efforts in Colorado, Oklahoma, and Pennsylvania identified a significant portion of rural uninsured children, while enrollment success in Kansas and West Virginia was more modest. However, limited access to care in rural areas remains a concern. Many providers did not participate or were dissatisfied with CHIP or Medicaid because of objections to managed care, administrative burdens, or perceived inadequate compensation. (Contains references in footnotes.) (SV)

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Jennifer L. Dunbar, M.H.S.
Harvey I. Sloane, M.D.
Curt D. Mueller, Ph.D.

The Project HOPE Walsh Center for Rural Health Analysis
7500 Old Georgetown Road
Suite 600
Bethesda, Maryland 20814-6133

November 1999

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This study was funded under a cooperative agreement with the federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, DHHS (#CSURC0005-03). The authors thank the many persons who contributed information used to prepare this report – in particular, sources from the states of Colorado, Kansas, Oklahoma, Pennsylvania, and West Virginia. The conclusions and opinions expressed in this report, however, are the authors' alone; no endorsement by Project HOPE, ORHP, or other sources of information is intended or should be inferred.

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Project HOPE Walsh Center for Rural Health Analysis
7500 Old Georgetown Road, Suite 600
Bethesda, Maryland 20814
301-656-7401
301-654-0629 (fax)
www.projhope.org

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Implementation of the State Children's Health Insurance Program: Outreach, Enrollment, and Provider Participation in Rural Areas

Executive Summary

Purpose

Inability to afford care is a major factor explaining difficulties in obtaining needed health care.[1] The State Children's Health Insurance Program (CHIP) provides states with an important source of funding for helping low-income, uninsured children overcome financial barriers to medical care. There is considerable interest among federal policy makers and rural advocates that CHIP may be especially important in providing coverage to children living in rural areas. Previous research found that children in rural areas are more likely to be uninsured than their urban counterparts. Many uninsured children are not enrolled in public insurance programs for which they are eligible and this problem may be exacerbated in rural areas. Approximately 1.3 million children,[2] 42 percent of those eligible under federal guidelines and 50 percent of those eligible under state plans,[3] were enrolled in CHIP as of June 1999. However, no research to date evaluates its progress in enrolling and providing services to children living in rural areas. This study responds to these concerns by qualitatively assessing outreach, enrollment, and provider issues in Colorado, Kansas, Oklahoma, Pennsylvania, and West Virginia. It follows an earlier Walsh Center report that examined aspects of children's health insurance programs in existence prior to passage of CHIP.[4]

Under CHIP, states receive federal matching funds to expand eligibility under their Medicaid programs, to create a separate state program, or to combine these options. To be eligible for federal funds, states must receive approval from the Department of Health and Human Services for their selected strategy. To address the well-documented difficulty in enrolling children into programs for which they are eligible, states have two sources of funding for their outreach activities. States may spend 10 percent of CHIP funds on program administration, outreach activities, health services initiatives and direct purchase of services. States have an opportunity to target rural areas in the use of these funds. The Robert Wood Johnson Foundation (RWJF) has funded a $47 million outreach initiative, called Covering Kids, to assist states and communities to increase the number of eligible children benefitting from various health insurance programs such as CHIP, Medicaid, and other programs.

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[1] Weinick RM, Weigers ME, Cohen JW: Children's health insurance, access to care, and health status: new findings. *Health Affairs*. 17(2): 127-136, 1998.

[2] SmithVK: *Preliminary Estimates: Enrollment Increases in State CHIP Programs: December 1998 to June 1999*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999.

[3] Selden TM, Banthin JS, Cohen JW: Waiting in the wings: eligibility and enrollment in the state children's health insurance program. *Health Affairs*. 18(2): 126-133, 1999.

[4] Dunbar JL, Mueller CD: *Anticipating the 1997 State Children's Health Insurance Program: What's Current in Five Rural States?* Prepared for the Federal Office of Rural Health Policy. Bethesda, MD: Project HOPE Walsh Center for Rural Health Analysis, 1998.

We obtained extensive program information from states' CHIP plans, including information on plans' characteristics, outreach strategies, enrollment goals, and provider participation issues. We conducted quasi-structured interviews with a range of state and county level informants and received enrollment figures by county from each state. Informants included:

- officials representing CHIP plans and state Medicaid agencies;
- representatives of state offices of rural health;
- representatives of RWJF Covering Kids grantees at the state and county level;
- representatives of public-private children's health insurance programs;
- representatives of state medical and dental societies;
- county health officers; and
- physicians.

The state programs examined were Colorado Child Health Plan Plus (CHP+), Kansas HealthWave, Oklahoma SoonerCare, Pennsylvania Children's Health Insurance Program, and West Virginia Children's Health Insurance Program. These programs represent a mixture of CHIP design strategies and varying length of experience in administering CHIP. In the following section, we briefly describe the state's approach to CHIP, rural outreach strategies, enrollment, and provider participation issues. In the final section, we examine these themes across states and implications for the future.

Colorado Child Health Plan Plus

The Colorado Child Health Plan Plus (CHP+) provides comprehensive benefits to uninsured children as a private, separate health insurance program. CHP+ expands the limited benefits provided by the Colorado Child Health Plan (CCHP), the state's pre-CHIP program, to comprehensive coverage. In counties where HMO enrollment is available, families select an HMO and primary care physician. In counties where HMO enrollment is unavailable, affecting approximately 15 percent of the CHP+ eligible population, families receive services through the CHP+ provider network. In these areas, primary care services are reimbursed through capitation while other services are reimbursed on a fee-for-service basis.

Rural Outreach Strategies

At the state level, Colorado has initiated several strategies to facilitate enrollment in CHP+ and Medicaid, including referral arrangements, joint applications, and outstationed eligibility workers. The state has also simplified the CHP+ enrollment process through the adoption of one-year guaranteed eligibility for CHP+, a shortened application, and by allowing families to self-report their resources on the application. One limitation to the state's application process is the requirement of an asset test, though the state anticipates that this will be eliminated in the coming months.

CHP+ distributes applications and brochures to organizations that serve families and children across the state, including public health offices, schools, community health centers and social service offices. Families may request applications through a toll-free telephone number or an internet site and may receive assistance in completing the application through providers, school enrollment campaigns, or other public programs serving the target population. According to the state plan, outreach and application assistance will specifically focus on children in rural and frontier areas. The state is operationalizing this goal through the establishment of satellite eligibility determination sites in many rural communities.

Colorado's Covering Kids initiative is enhancing CHP+'s outreach efforts as well as examining why families with access to low or no cost coverage do not enroll. The initiative is sponsoring several evaluations to contact families who requested applications but did not apply. A Covering Kids pilot project in rural Prowers County conducts outreach activities and application assistance at community events, such as school registration, basketball games, and PTA meetings and through small businesses that do not offer insurance. They have also produced local public service announcements featuring school nurses, well known to local parents, who tell a true story illustrating the benefits of insurance for children.

Enrollment

As of August 1999, CHP+ had enrolled approximately 25 percent of the potentially eligible population since it began operating in April 1998. Among those enrolled, the state estimates that 4,000 of 19,000 enrolled children were from rural areas. The original CCHP was specifically designed to target uninsured children in rural areas; however, the direction of the program in future years will likely concentrate more attention on urban areas because of greater urban poverty and uninsurance. Monitoring of enrollment by rural advocates may be appropriate.

Rural Provider Participation Issues

Physicians and other providers we spoke to expressed substantial frustration in dealing with CHP+ administration and reimbursement issues. Several non-HMO primary care providers felt that the capitation amount results in the provision of care at a loss to the provider. Other physicians described extensive paperwork and substantial delays in reimbursement as frustrating. The program is currently recontracting with physicians, but it is unsure as to what effect these frustrations will have on the numbers of physicians who elect to participate. The state is willing to negotiate a separate contract for fee-for-service reimbursement for providers who do not have a sufficient number of CHP+ enrollees to support a capitation arrangement.

Kansas' HealthWave Program

Kansas' HealthWave, a separate, non-Medicaid CHIP program, extends EPSDT-equivalent coverage to children ineligible for Medicaid. HealthWave children are served through mandatory capitated managed care systems.

Rural Outreach Strategies

HealthWave is being promoted across the state through several strategies, including a toll-free hotline, public service announcements, inserts in utility bills, community outreach workers, and coordination with other state and community agencies, specifically public schools and the free or reduced price school lunch programs. The state is also focusing specific attention on enrolling its Native American population.

Kansas has initiated several strategies to coordinate the HealthWave and Medicaid programs, including a joint application and one-year continuous eligibility for both programs. In the next few years, HealthWave and Medicaid will become one program that differs only in payment source.

The Kansas Children's Service League, the state Covering Kids grantee, administers several statewide outreach initiatives that extend state-level activities and provide outreach tailored to individual communities. A statewide coordinator is recruiting 300 volunteers across the state to conduct outreach within their communities. Mercy Health System of Kansas operates a Covering Kids pilot project in the rural southeast portion of the state. Mercy is enlisting knowledgeable people to provide information and application assistance in places frequented by potential HealthWave eligibles, such as during health care visits, trips to department stores, and through employers. In the coming months, Mercy will set up a booth at the annual fall festival, an event that attracts families from neighboring counties. They are also recruiting volunteers and have recently hired a site coordinator from the area, a person who "knows everyone." The United Methodist Mexican-American Ministries also has a Covering Kids pilot project in the rural southwest corner of the state. Starting on July 1, 1999, outreach activities will target families at school registration, hospital maternity wards, adult learning centers, community police substations, and through area employers.

Barriers to effective outreach include the state's crowd out policy and the federal 10 percent limit on administrative funds, which includes funds that can be used to support outreach activities. Kansas has had difficulties obtaining funds for early outreach because the 10 percent limit is based on program expenditures. Because HealthWave was a new, separate program, high administrative start-up costs were necessary before expenditures could be directed to delivering care to enrollees. Another barrier is consumers' association of HealthWave with the stigma of welfare.

Enrollment

Kansas is well on its way to meeting its goal of insuring 30,000 children by December 31, 1999. As of June 1999, over 11,000 children had been enrolled in HealthWave and 11,300 in Medicaid. Though our respondents noted that enrollment in rural areas is limited and much higher in the major cities, HealthWave has enrolled children in each of the state's 105 counties.

Rural Provider Participation Issues

We heard conflicting reports from providers serving HealthWave and Medicaid about their relationships with the programs. Generally, we found that physicians dislike managed care across the state, with particular participation problems apparent in the southwest. We heard that rural physicians have few incentives to join HealthWave's managed care networks. As a result, the HealthWave plans have negotiated fee-for-service reimbursement for rural providers to ensure that each enrollee is within 30 miles of a provider.

Community health clinic personnel in southwest Kansas told us that few area specialists and hospitals are participating in HealthWave because the program insures so few of their patients. Since specialists will not affiliate with HealthWave, primary care providers also decline since they can not make referrals and can not be responsible for the full continuum of specialty care. We heard from our state contacts that providers in the southwest have a particularly strong dislike for managed care, a dislike established long before implementation of HealthWave. In contrast, we found physicians in other areas of the state to have a positive perception of HealthWave and enthusiasm for the program's goal.

Delta Dental, a managed care organization serving HealthWave, has been able to secure the participation of approximately 450 dentists, 80 percent of its providers. Delta was able to bring approximately 450 (80 percent) of their dental providers into HealthWave. This high participation rate may be due to the fact that Delta pays 80 percent of the usual and customary rate (UCR). In contrast, only a quarter of Kansas dentists participate in Medicaid, which pays 50-60 percent of the UCR. In the eastern part of the state, Doral Dentist was awarded the CHIP contract, but only has about 35 providers currently participating.

Oklahoma's SoonerCare Program

Oklahoma expanded its Medicaid program, SoonerCare, in response to federal passage of CHIP. SoonerCare is split into two programs – SoonerCare Plus and SoonerCare Choice – to serve Medicaid recipients in urban and rural areas. Comprehensive services, including behavioral health, are fully capitated to urban beneficiaries under SoonerCare Plus. Primary care office visits, case management, and

diagnostic and ancillary services are provided to rural beneficiaries through a partially capitated arrangement under SoonerCare Choice.

Rural Outreach Strategies

The state took several steps to simplify the SoonerCare application process, including shortening the application forms, eliminating the assets test and in-person interviews, and implementing a toll-free telephone help line. As part of its expansion, the state initiated its first Medicaid marketing and outreach campaign. The campaign includes written materials, such as flyers, brochures, and posters, and a 30-second public service announcement. The state intends to disseminate information locally, through community and social service agencies, providers, employers, and direct mail. It has also hired 47 outreach workers charged with designing programs that meet the specific needs of assigned counties.

In interviews with outreach workers serving rural counties, we found that workers identified the school system and school registration as central to their outreach activities. They also described providers as active participants in enrollment activities. In one case, a physician's office displayed eligibility and application information prepared by an outreach worker. The outreach workers have also provided SoonerCare information during health care visits and through coordination with a minimum-wage local employer. Other strategies include developing partnerships with other agencies concerned with children and families.

Barriers to enrollment focus on public awareness. Repeatedly we heard that potential enrollees are unaware of the benefits of health insurance and the revised eligibility standards, and may perceive an association with welfare. Until May 1999, the federal government had not specified whether immigrant children could participate in CHIP without jeopardizing their status and outreach workers said this was a significant barrier to a number of potential applicants.

Enrollment

Oklahoma enrolled 17,521 children, or 43 percent of the eligible population, between December 1, 1997 and September 30, 1998, a figure very close to its stated goal of 45 percent. Another 27,000 have been enrolled in traditional Medicaid. During February and March of 1999, the state witnessed a spike in rural enrollment, with rural enrollment exceeding urban enrollment. CHIP program officials are uncertain as to the exact reason for this difference, but believe it may be attributable to its county outreach workers.

Rural Provider Participation Issues

It appears that SoonerCare will have difficulties in assuring access to medical and dental services to children in rural areas. While a few providers seemed relatively satisfied with SoonerCare, others voiced concerns with claims processing and auto-

enrollment and registered limited willingness to participate. We repeatedly heard that providers in rural areas and elsewhere refuse to participate in SoonerCare because of a dislike of managed care. When SoonerCare went into effect, 13 of 14 physicians in one rural county stopped seeing Medicaid patients because they did not want to participate in managed care. Recently, the remaining physician stopped participating because of administrative difficulties and inadequate reimbursement.

Over the past ten years the Oklahoma Medicaid program has witnessed a significant decline in participation by dentists. Between 1987 and 1998, the number of participating dentists declined from 1,021 to 171. The Oklahoma Dental Association said the problem is that dentists are paid only half of their traditional fee and they are not able to cover costs by treating enrollees. The Association also reported that HCFA would soon document the state as out of compliance with federal dental requirements for Medicaid children.

Pennsylvania's Children's Health Insurance Program

Continuing its long-standing Children's Health Insurance Program (CHIP), Pennsylvania selected a separate program for insuring children under Title XXI. The state contracts with five managed care organizations to administer CHIP across the state.

Rural Outreach Strategies

The state, through the Department of Insurance, the Medicaid Bureau, participating managed care plans, and advocates, has begun work on a simplified, joint application for CHIP and Medicaid. Additionally, the state has developed a referral arrangement between the two programs. Simplification techniques include a mail-in application, elimination of the assets test, one-year guaranteed coverage, and annual recertification.

CHIP managed care organizations assume primary responsibility for outreach. The state has used its 10-percent funds to enhance these efforts. The contractors use bilingual media approaches and advertisements in public places, such as on buses and in movie theaters. Each contractor has an outreach coordinator who conducts outreach activities at health fairs, schools, and community events. The state plans to work in consultation with other agencies and managed care plans to develop provisions for reaching special populations, including children in rural areas.

We found that outreach efforts in rural communities focus on coordinating with local agencies serving children and families. Cornerstone Care, a network of three community health clinics, operates a Covering Kids pilot project across three rural counties in southwestern Pennsylvania. A coalition of social service organizations in each county guides and participates in outreach activities and assists with enrollment.

As in other states, we found that barriers to enrollment were related to public awareness. Relatively higher-income families may be unaware of potential CHIP eligibility simply because they have not been the focus of older public programs and may think an enrollment cap from 1997 is still in effect. Our respondents were also concerned that families who have a poor opinion of Medicaid or associate Medicaid or CHIP with welfare may not enroll. Additionally, families struggling with daily subsistence concerns may not perceive health insurance as a priority.

Enrollment

Pennsylvania CHIP has added an estimated 21,000 children to its enrollment since the federal CHIP program began in 1997. The state's total enrollment had nearly reached 75,000 children as of April 1, 1999. Enrollment in selected rural counties increased as fast as the state as a whole.

Rural Provider Participation Issues

Physicians perceive CHIP positively because it seems to have improved their patients' access to care. While providers we spoke with supported the goals of CHIP, other sources described difficulties experienced by some managed care organizations in contracting with rural providers. As we learned in our previous report, CHIP had begun a move toward more managed care and perhaps providers are reluctant to affiliate with managed care plans.

Physicians feel that the current level of reimbursement does not support the provision of thorough and comprehensive medical assessments in well-child health care. Providers receive a smaller payment for serving CHIP children than Medicaid children, though the state is expected to address this difference.

West Virginia's Children's Health Insurance Program

West Virginia selected a two-phased approach to CHIP. Phase I expands Medicaid coverage to children between age one and five, while Phase II is a private, separate program serving older children. Children to age one are served by traditional Medicaid. Across the state, Phase I children are served through a mandatory primary care case management program; areas along the state's western Pennsylvania border and the two counties in and around its capital city, Charleston, are served through mandatory managed care plans. Phase II children are served through fee-for-service arrangements.

Rural Outreach Strategies

Statewide administrative simplification efforts to increase enrollment include a guarantee of one year of continuous eligibility, coordination of CHIP with other public programs, adoption of mail-in applications, and adoption of an automated eligibility system. In-person interviews are not required for either Phase, though they are required

for Medicaid. CHIP information and applications have been distributed to public schools statewide.

The state has begun several activities to disseminate CHIP information at the local level, through a toll-free telephone line and distribution to various local service agencies. CHIP applications and assistance in completing the application are available at health care sites and other places families frequent, including rural health clinics, child care centers, and libraries. The West Virginia Healthy Kids Coalition, a Covering Kids grantee, has hired nine outreach coordinators to conduct activities at the county level.

We found several outreach examples targeting children in rural areas. A physician in a rural county increased CHIP enrollment through her own efforts to inform and enroll her patients in the program. One of the state's three Covering Kids pilot projects targets rural counties and its CHIP coordinator has conducted outreach at several fairs and festivals, has assisted families in completing the application, and coordinates with various community agencies to distribute CHIP information.

While the state has not encountered barriers to enrollment of rural children, officials are concerned that families may not understand the importance of primary and preventive care and require assistance in solving transportation difficulties.

Enrollment

As of June 11, 1999, 3,818 children had been insured through CHIP, with 31 percent of these eligible for traditional Medicaid. The state anticipates that 1,741 children are eligible under Phase I and 22,901 under Phase II. Based on these figures, Phase I currently covers 58 percent of eligible children, while Phase II covers 15 percent.

Rural Provider Participation Issues

The expansion of the children's health insurance program in West Virginia has had varying impact on physicians. Most rural physicians we spoke with knew little about the expansion and thought they had only one or two CHIP patients. Among members of the state Academy of Pediatrics there were few complaints, with most pediatricians looking forward to improvements in coverage. Neither the state Medical Society nor the state Academy of Pediatrics had any strong feelings about the expansion of CHIP and it seemed to be working well, but the number of enrolled patients seen by physicians is not large.

In discussions with the state Dental Association, we heard that approximately 400 of the state's 900 dentists participate in Medicaid. Since reimbursement is the same across Medicaid and CHIP, the Association felt that dentists who participate in Medicaid are likely to participate in both phases. However, the administrator for Phase II experienced delays in operationalizing the dental benefit and these children did not begin receiving dental services until July 1999.

Implications

We find states more aggressive in outreach and enrollment activities in rural areas under CHIP than in children's insurance programs prior to CHIP. The RWJF Covering Kids initiative is an important funding source for many of the rural outreach activities in our study states. CHIP officials in these states appear to be concerned with enrolling hard-to-reach populations and have identified children in rural areas as part of this population. Our interviews revealed many examples of outreach efforts specifically targeted to rural communities, primarily conducted through people, places, and organizations with which families have significant contact. States are experiencing common barriers to enrollment including misunderstandings among beneficiaries about the nature of and qualifications for CHIP. Concern with immigration status may also impact enrollment success for immigrant families.

Although data on enrollment by county varied in content across the studied states, efforts in these states appeared to be progressing toward a significant increase in health insurance coverage among their targeted populations. Data from Colorado, Oklahoma, and Pennsylvania revealed that CHIP efforts identified a significant portion of their uninsured children living in rural areas. Enrollment success in Kansas and West Virginia was more modest; in some counties, enrollment over several months kept pace or exceeded the change in overall state enrollment, whereas enrollment in other counties lagged behind the state. As preparation of this report was nearing completion, we obtained follow-up data for Kansas, Pennsylvania, and West Virginia. This data indicated that the percent change in enrollment in rural counties is no different from urban counties.

We remain concerned that children enrolled in CHIP may experience limited access to care in rural areas. Many providers have strong, positive commitments to CHIP's goals, yet do not participate or are dissatisfied with CHIP or Medicaid because of their objections to managed care, administrative burdens, and perceived inadequacies of reimbursement. We also found evidence in some states of difficulties in securing the participation of dentists. Further research is needed to determine whether CHIP enrollment will improve access to care. Other questions to address in the future include: Will the provider capacity of rural areas adequately support services to CHIP children? Will enrollment in rural areas keep pace with that of enrollment in urban areas? How can resistance to government-sponsored programs and welfare stigma be overcome? Will states that expand their Medicaid programs capitalize on the efficiencies of the existing system or will separate approaches, possibly based more on private sector models, have greater success in enrollment? Will children fair well under managed care versus fee-for-service arrangements? We are hopeful that we will see further improvements in outreach and enrollment of children in rural areas as implementation efforts continue.

CHAPTER 1: Introduction

Purpose of Study

Inability to afford care is a major factor explaining difficulties in obtaining needed health care.[5] The State Children's Health Insurance Program (CHIP) provides states with an important source of funding for helping low-income, uninsured children overcome financial barriers to medical care, especially among children living in rural areas. There is considerable interest among policy makers that CHIP be carefully monitored from the rural perspective. The Rural Work Group of the federal Interagency Task Force on Children's Health Insurance Outreach recognizes the need for outreach targeted to children living in rural and frontier areas. Representatives from the Department of Health and Human Services met with the National Rural Development Partnership in March 1999 to discuss the implementation of CHIP in rural areas. The National Rural Health Association, as part of its regulatory and legislative agendas, recommends that states implementing CHIP specifically address the unmet needs of children in rural, under-served areas.

Approximately 1.3 million children,[6] 42 percent of those eligible under federal guidelines and 50 percent of those eligible under state plans,[7] were enrolled in CHIP as of June 1999. However, no research to date evaluates its progress in enrolling and providing services to children living in rural areas. From the Medical Expenditure Panel Survey, we previously found that children in rural areas are more likely to be uninsured than their urban counterparts, 21 percent versus 14 percent.[8] While disparities exist in rates of insurance, other research documents the difficulty in enrolling individuals into programs for which they are eligible. An estimated 4.7 million children under age 18 are eligible for Medicaid but are not enrolled.[9] This problem may be exacerbated in rural areas. In examining the enrollment of rural residents in MinnesotaCare, a state-subsidized health insurance program for the uninsured under age 65, Yawn and Krein[10] found that rural counties varied in enrollment from 1.5 percent to 10.8 percent of the eligible population. HCFA and the state governments may oversee CHIP

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[5] Weinick RM, Weigers ME, Cohen JW: Children's health insurance, access to care, and health status: new findings. *Health Affairs*. 17(2): 127-136, 1998.

[6] SmithVK: *Preliminary Estimates: Enrollment Increases in State CHIP Programs: December 1998 to June 1999*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999.

[7] Selden TM, Banthin JS, Cohen JW: Waiting in the wings: eligibility and enrollment in the state children's health insurance program. *Health Affairs*. 18(2): 126-133, 1999.

[8] Dunbar JL, Mueller CD: *Anticipating the 1997 State Children's Health Insurance Program: What's Current in Five Rural States?* Prepared for the Federal Office of Rural Health Policy. Bethesda, MD: Project HOPE Walsh Center for Rural Health Analysis, 1998.

[9] Selden TM, Banthin JS, Cohen JW: Medicaid's problem children: eligible but not enrolled. *Health Affairs*. 17(3):192-200, 1998.

[10] Yawn BP, Krein S: Rural enrollment in MinnesotaCare. *Minnesota Medicine*. 80:42-49, 1997.

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implementation, but there is no indication that the Federal and state governments will pursue a rural focus. Special outreach efforts and means of securing provider participation are needed as well as oversight on these issues to ensure those children living in rural areas are enrolled in CHIP.

This study responds to these concerns by qualitatively assessing outreach, enrollment, and provider issues across five states. It follows an earlier Walsh Center report that examined aspects of children's health insurance programs in existence prior to passage of CHIP.

Background

Summary of Federal Legislation

Passed by Congress as part of the Balanced Budget Act of 1997, CHIP provides funds for health insurance to low-income, uninsured children. Nearly $40 billion will be available to states over the ten years of the program. States may choose to expand eligibility under their Medicaid programs, to create a separate program, or to combine these options.

To be eligible for funds, states must have a plan approved by the Secretary of the Department of Health and Human Services describing their selected strategy. Each state receives an allocation based on the number of uninsured children with family income at or below 200 percent of poverty, adjusted for regional variations in health care costs. The allocation is distributed to states on a matching basis, where states spend a portion of their funds to receive federal funds. The portion of state spending is based on each state's enhanced federal medical assistance percentage (FMAP). The enhanced FMAP equals the current FMAP (used to fund the state's Medicaid program), increased by 30 percent of the difference between 100 percent and the current FMAP. It may not exceed 85 percent.

Eligibility for separate state programs is limited to "targeted low-income children," defined as children whose family income exceeds the Medicaid eligibility threshold by no more than 50 percent, or whose family income is at or below 200 percent of poverty. Eligibility for a Medicaid expansion includes "optional targeted low-income children," who were ineligible for Medicaid based on the state's requirements in effect on April 15, 1997.

States may limit coverage to children residing in certain parts of the state and may spend 10 percent of CHIP funds on program administration, outreach activities, health services initiatives and direct purchase of services. States have an opportunity to target rural areas in the use of these funds. This expenditure cap is known as the "10 percent limit." The Secretary may approve waivers for states wishing to appropriate more than 10 percent of CHIP funds to these activities.

Covering Kids

In addition to interests in the program's success among federal and state policymakers, considerable private-sector funding has been targeted at the program. The Robert Wood Johnson Foundation (RWJF) has funded a $47 million outreach initiative called "Covering Kids: A National Health Access Initiative for Low-Income Uninsured Children," hereafter referred to as Covering Kids. Directed by the Southern Institute on Children and Families, Covering Kids seeks to assist states and communities in increasing the number of eligible children benefitting from various health insurance programs such as CHIP, Medicaid, and other programs through grant funds from RWJF. All 50 states have received a Covering Kids grant.

Each state grant effort is led by one organization, such as an advocacy group, insurance program, or religious organization, and is supported by a coalition of other state-based organizations that assist in program goals. These goals include: design and implementation of outreach programs that identify and enroll eligible children into Medicaid and other coverage programs; simplification of enrollment processes; and coordination of existing coverage programs for low-income children. State organizations coordinate pilot projects at the community level. These projects may address one or a combination of the above goals.

Selection of State Programs and Rural Areas

We originally planned to study the first five states to fully implement their CHIP plans. We sought guidance from federal officials with the Health Care Financing Administration, the Maternal and Child Health Bureau, the Federal Office of Rural Health Policy, and the Covering Kids National Program Office. During this process, we found that plan approval and estimated start-up dates were not indicative of progress in enrolling children and we were left with the difficult task of determining how far states had advanced with implementation. For our original study, we identified states based on the size of their population residing in rural areas and aspects of their pre-CHIP efforts to expand children's health insurance coverage. For example, we included Colorado because its major effort to expand coverage originated in rural counties.

We decided to re-examine the states studied in our previous assessment: Colorado, Kansas, Oklahoma, Pennsylvania, and West Virginia.[11] These states had chosen a mixture of CHIP design strategies and had varying experience in administering their programs. The characteristics of CHIP plans and relevant population data are presented in Table 1.

[11] Dunbar and Mueller, 1998.

Table 1
Characteristics of Selected CHIP Programs

State	Date of Plan Start or HCFA approval	Type of CHIP Plan	Potential CHIP Eligibles*	Non-Metropolitan Population, 1996**	CHIP Eligibles in Rural Areas
Colorado	4/22/98	Separate	94,000	16%	15,040
Kansas	1/1/99	Separate	53,000	45%	23,638
Oklahoma	12/97	Medicaid	143,000	40%	63,778
Pennsylvania	5/98	Separate	172,000	15%	44,892
West Virginia	9/15/98	Combination	26,000	58%	15,132

*Children under age 19 without health insurance from families with income less than 200 percent of the federal poverty level (FPL) 1995-1997. US Census Bureau: Low Income Uninsured Children by State, http://www.census.gov/ftp/pub/hhes/hlthins/lowinckid.html.
**US Census Bureau: *Statistical Abstract of the United States 1998 (118th Edition)*. Washington, DC Government Printing Office, 1998.

We also focused on CHIP experiences in a sample of five rural counties within each state. We randomly selected counties with an Urban Influence Code of 4 or 6 through 9.[12] This means our definition of "rural" includes those counties not adjacent to a metropolitan area, or adjacent to a metropolitan area but containing a city of no more than 10,000 persons. Selected counties are shown in Table 2.

Table 2
Selected Rural Counties

Colorado	*Kansas*	*Oklahoma*	*Pennsylvania*	*West Virginia*
Custer	Cloud	Custer	Adams	Braxton
Garfield	Kingman	Garvin	Bradford	Harrison
La Plata	Marion	Johnston	Clinton	McDowell
Mesa	Neosho	Love	Greene	Preston
Teller	Stafford	Mayes	Monroe	Upshur

[12] The probability of selection was in proportion to the rural county's population.

Research Questions

We addressed the following policy questions:

- what CHIP outreach strategies are in use and have helped enroll children in rural areas?
- has CHIP improved insurance coverage among children in rural areas?
- have CHIP programs ensured participation of pediatric providers in rural areas?

We defined outreach efforts as both the methods used to identify potentially eligible low-income children and methods used to enroll them in the appropriate program, including the application process.

We obtained extensive program information from states' CHIP plans, including information on plans' characteristics, outreach strategies, enrollment goals, and provider participation issues. We conducted quasi-structured interviews with a range of state and county level informants and received enrollment figures by county from each state. Though the type of informants varied by program and state, we conducted interviews with the following persons:

- officials representing CHIP plans and state Medicaid agencies;
- representatives of state offices of rural health;
- RWJF Covering Kids grantees at the state and county level;
- representatives of public-private children's health insurance programs;
- representatives of state medical and dental societies;
- county health officers; and
- physicians.

Our by-state analyses are based on syntheses of this assortment of information.

Organization of Report

In the next chapter, we identify issues of concern to all states, especially those enrolling a significant portion of children living in rural areas. Findings for each state are reported in Chapters 3-7. For each state, we briefly describe the state's approach to CHIP, rural outreach strategies, enrollment, and provider participation issues. In the final chapter, we examine themes across states in these areas and implications for other states and for the future.

CHAPTER 2: Issues Concerning Enrollment of Children Living in Rural Areas

Since the CHIP legislation was enacted, several issues have arisen which have affected program design and implementation across states. In fact, persons to whom we have spoken repeatedly identified these issues as impacting the willingness of potential enrollees to apply, the availability of outreach funds, and the unintended consequences of welfare reform.

Clarification of "Public Charge" Rules For Immigrants

The Immigration and Naturalization (INS) or the State Department determines permanent residency for immigrants based in part on whether the person is likely to become a "public charge," someone who depends on the government for subsistence. The U.S. General Accounting Office found that fear of compromising their immigrant status was a primary reason why Medicaid-eligible, but uninsured immigrant children had not applied for Medicaid.[13] These concerns appear to have had a widespread and serious affect on immigrants' ability and willingness to access public services.[14] From our interviews, we learned that this has deterred immigrant enrollment in Oklahoma's SoonerCare program. Enrollment may also be discouraged in Colorado and Kansas, states with large Hispanic populations.

On May 26, 1999, the Clinton administration clarified which services may and may not be considered in making a public charge determination. Immigrant children and adults may enroll in Medicaid and CHIP, as well as other health, housing, and social programs, without jeopardizing the immigration status of themselves or their families. Since more than one-third of uninsured Medicaid-eligible children live in immigrant families,[15] this is an important category of potential enrollees. Since this clarification comes well after states have begun implementation of CHIP programs, it is unclear how successful outreach efforts will be in assuring immigrant families that they run no risk in applying for the program.

CHIP and the Indian Health Service

Children eligible for or receiving services from the Indian Health Service (IHS) may also be eligible for CHIP under the same age and income criteria required of other children in their state. Regardless of the state's structure, CHIP will pay for services covered under its benefit package and delivered by IHS providers participating in the

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[13] U.S. General Accounting Office (GAO): *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies*. GAO/HEHS-98-93. Washington, DC: GAO, 1998.

[14] Ellwood M, Ku L: Welfare and immigration reforms: unintended side effects for Medicaid. *Health Affairs*. 17(3):137-151, 1998.

[15] GAO, 1998.

CHIP plan. IHS and IHS-funded tribal health programs continue to serve as the "payor of last resort," where IHS only pays for items and services not covered by CHIP or other third-party coverage.[16] We heard from a state source in Oklahoma that IHS providers had mistakenly told their patients that they were ineligible for the state's CHIP program.

Welfare Reform and Outreach Funds

In 1997, children under age 19 represented two-thirds of those who lost their Medicaid coverage as a result of welfare reform. Most of these children were still eligible for Medicaid and should not have lost coverage.[17] To alert families to the possibility that their children may still be eligible for Medicaid, even if they are no longer eligible for cash assistance, the welfare reform law allows Medicaid administrative funds to be used for outreach and enrollment at a higher matching rate than in the past.[18] Administrative matching funds totaling $500 million can be used by the states to ensure that persons not eligible for cash assistance do not lose Medicaid coverage. These funds can be matched at 90 percent by the federal government up to the state's total allotment, up from the normal 50 percent match normally available.[19] These funds could boost traditional Medicaid enrollment, one of CHIP's goals, as well as increase the visibility of state health insurance programs generally. However, availability of these funds will expire for 16 states by September 30, 1999 and for 18 more states by December 31, 1999, even though states have used less than 8 percent of federal funds. While our other study states have until spring of 2000, the September expiration date applies to Kansas and Oklahoma.[20]

The 10 Percent Limit

Though states may spend 10 percent of CHIP funds on program administration, outreach activities, health services initiatives, and direct purchase of services, the 10 percent amount is based on CHIP *expenditures*, rather than the state's expected total allotment. This has resulted in difficulties for states with low or no program expenditures (e.g., if the program has only recently begun enrollment), and in states where outreach efforts are conducted prior to enrollment. The President's budget proposal, announced in February 1999, contained a legislative proposal to create a new funding source for CHIP outreach. However, appropriations had not been passed as of this printing. In its first

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[16] Health Care Financing Administration: *Q&A*. November 26, 1997; Health Care Financing Administration: *Q&A* July 29, 1997.

[17] Families USA: *Losing Health Insurance - The Unintended Consequences of Welfare Reform*. Washington, DC: Author, 1999.

[18] Center on Budget and Policy Priorities: *Steps States Can Take to Facilitate Medicaid Enrollment of Children*. Washington, DC: Author, 1998.

[19] DeChiara, M, Wolff T: Topics for our times: if we have the money, why is it so hard? *American Journal of Public Health*. 88:1300-1302, 1998.

[20] Families USA: *Alert! Medicaid/TANF $500 Million Fund Scheduled to Expire*. Washington, DC: Author, 1999.

report to HCFA, Oklahoma asked that the 10 percent of funds be based on a state's total federal allotment rather than its total CHIP expenditures. Kansas also had a particularly difficult time funding outreach, as its new, separate program experienced high administrative start-up costs prior to funding of care.

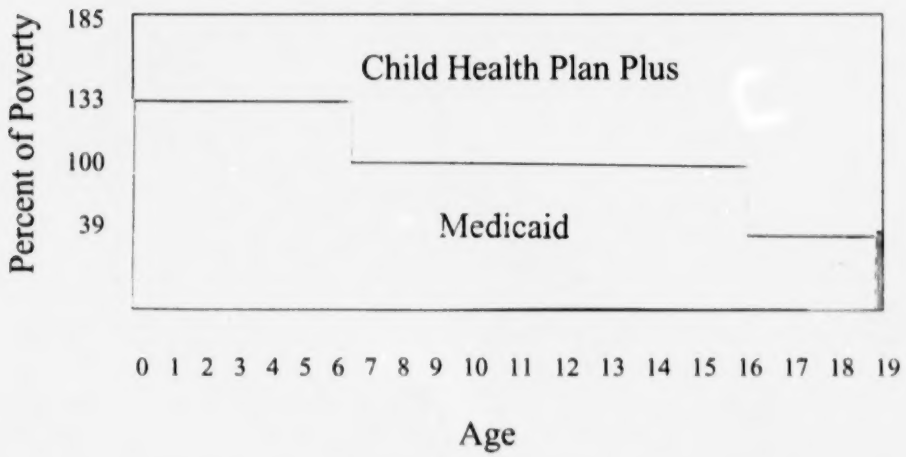
CHAPTER 3: Colorado Child Health Plan Plus

Plan Overview

The Colorado Child Health Plan Plus (CHP+)[21] supplements the state's Medicaid program by providing comprehensive benefits to uninsured children. It provides more generous benefits than were provided by the Colorado Child Health Plan (CCHP), the state's pre-CHIP program. Originally designed to provide coverage to the uninsured children of rural areas in 1992, CCHP stopped taking new applications in March 1998, with its enrollees considered eligible for CHP+. Many CCHP enrollees were transferred to CHP+ when it began operating on April 22, 1998, and all new eligible applicants have been enrolled directly in CHP+.

Colorado residents age 18 and under in families with incomes below 185 percent of the federal poverty level are eligible for CHP+. Medicaid covers children from birth through five years of age in families with income up to 133 percent of poverty, ages six through 15 in families with income up to 100 percent of poverty, and ages 16 through 18 in families with income up to 39 percent of poverty. While the state projects enrollment of 23,047 children based on current funding by its fiscal year 1999-2000, an estimated 75,000 children are potentially eligible for CHP+. Figure 1 displays the age and income standards for CHP+ and Medicaid.

Figure 1: COLORADO
Age and Income Eligibility Standards
for Children's Health Insurance Programs



[21] Colorado's Title XXI program is officially known as the Children's Basic Health Plan. During the first phase of Title XXI implementation, however, the program will be known as the Child Health Plan Plus.

The Colorado Department of Health Care Policy and Financing (DHCPF) administers CHP+, contracting eligibility, enrollment, marketing, and outreach to Child Health Advocates. Within the DHCPF, the Title V agency functions as the statewide lead organization for Colorado's Covering Kids grant.

CHP+ benefits include physician and clinic services; inpatient and outpatient hospital care and surgical services; laboratory and radiological services; prescription drugs; family planning and prenatal care; limited inpatient and outpatient mental health services; limited outpatient substance abuse services; durable medical equipment and other devices; home and community-based care; limited abortion; habilitative and rehabilitative therapies; hospice care; hospital and emergency room transportation; organ transplant; vision and audiological services, intractable pain treatment; autism services; and skilled nursing facility services. Dental and enabling services are not covered.

Premiums and cost sharing are scaled according to family income. Families pay a premium if income is greater than 100 percent of poverty (Table 3). For families with income less than 150 percent of poverty, copayments up to $2 are applied to such services as prescription drugs and physician and clinic services. Copayments up to $5 apply to families with income over 150 percent of poverty. The state informs families of the five percent limit on cost-sharing and provides a mechanism for families to stop paying once that limit has been reached.

Table 3
Premiums Adjusted for Family Income and Number of Children

Family Income as a Percent of Poverty	Amount per Month with One Child	Amount per Month with Two or More Children
101-150	$9	$15
150-169	$15	$25
170-185	$20	$30

Source: Colorado Fact Sheet, http://www.hcfa.gov

CHP+ children are served through arrangements with managed care organizations and only by plans that also serve the Medicaid population. In counties where HMO enrollment is available,[22] families select an HMO and primary care physician. In counties where HMO enrollment is unavailable, affecting approximately 15 percent of the CHP+ eligible population, families receive services through the CHP+ provider network. The provider network may also serve newly enrolled children briefly while the

[22] Children who live in the following counties must select an HMO: Adams, Arapahoe, Boulder, Clear Creek, Conejos, Costilla, Denver, Douglas, El Paso, Gilpin, Huerfano, Jefferson, Larimer, Logan, Morgan, Phillips, Prowers, Pueblo, Rio Grande, Teller, Washington, Weld and Yuma County. Teller County is one of our five study counties.

HMO processes their enrollment applications. In these areas, primary care services are covered by capitation arrangements with primary care physicians while specialty, inpatient, and pharmaceutical providers are reimbursed on a fee-for-service basis. The CHP+ provider network includes over 1,000 primary care providers and over 1,500 participating specialty providers. The state has the capability to supplement the capitation amount for patients needing significant care, but, to date, this has not been operationalized. CHP+ will amend and continue contracts under CCHP with the Indian Health Service (IHS). The state's goal is to have few, if any, areas without HMO coverage.

Rural Outreach Strategies

Administrative Simplification

Colorado has initiated several strategies to facilitate enrollment in CHP+ and Medicaid, including referral arrangements across these two programs. CHP+ and Medicaid have collaborated to develop a joint application that will allow families to apply for both programs on the same form. CHP+ plans to pursue cooperative arrangements with county social service offices to exchange CHP+ and Medicaid information. Other coordination with Medicaid includes referral of likely eligibles to the Medicaid program by CHP+ and use of Medicaid outstationed eligibility and presumptive eligibility workers to determine CHP+ eligibility. Applicants for either program are asked to sign a release form allowing the state to check eligibility for the program not applied for. Children eligible for free or reduced price school lunches are referred to CHP+ and screened for Medicaid eligibility.

Other administrative simplification strategies have been adopted. Colorado has elected an automatic period of continuous eligibility for CHP+ enrollees lasting one year. A renewal packet is sent to enrollees' homes within 45 days of the child's anniversary date. Families may self-report their resources on the application without verification. Applications include quality indicators on participating health plans and a toll-free number to call for questions.

One limitation to the state's application process is the requirement of an asset test The asset test considers equity in the family's motor vehicle, business equity, and liquid assets, and offers allowances for family size and child care and medical expenses. The Department is in the process of updating its rules and procedures and is recommending the elimination of the assets test to the Board. A final determination on this recommendation is expected by early fall.

CHIP Information and Application Assistance

CHP+ distributes applications and brochures to organizations that serve families and children across the state, including local public health offices, public schools, community health centers and social service offices. Families may request an application through a CHP+ toll-free telephone number ("Family Health Line") and an Internet site (http://www.CCHP.org/). The program has been promoted through public service announcements, tear sheets, posters in English and Spanish, videos for provider offices and eligibility determination sites, and newspaper articles as well as quarterly provider and human services newsletters.

At the local level, CHP+ has developed 26 Community Enrollment Projects that reach out to eligible families and provide one-on-one assistance with CHP+ applications. Specialized outreach efforts target families enrolled in other state programs for low-income children, including WIC, the Health Care Program for Children with Special Needs, the Colorado Indigent Care Program, and IHS.

According to the state plan, outreach and application assistance will specifically target children in rural and frontier areas. Through our discussions with the DHCPF, we learned that the state is operationalizing this goal through its contract with Child Health Advocates. Child Health Advocates is establishing satellite eligibility determination sites in communities. As of June 1999, personnel in over 40 community sites had been trained for satellite duty. Many sites are in rural communities, including the Resource Center in Grand Junction, Mesa County and a community health center in south central rural Colorado. Colorado's automated eligibility system allows applications to be submitted over the Internet. Although this technology is available for use in only a few sites, it is expected to be available statewide in the near future. The DHCPF staff sees the Internet application as a great assistance to enrolling children who live in rural areas.

Colorado's Covering Kids initiative, led by DHCPF's Title V agency, is enhancing CHP+'s outreach efforts and examining why families with access to low or no cost coverage do not enroll. Parents are a key component of the statewide initiative as well as in the pilot programs. A Family Leadership Team, including a parent representative from each pilot community and a parent representative from statewide family advocacy groups, will guide CHP+ staff in a number of areas, such as administrative simplification, overcoming barriers to enrollment, and the design of outreach materials. The lead agency is sponsoring several evaluations, including one by Children's Hospital in Denver and one by CHP+, to contact families who requested applications but did not apply. One contact wondered whether high premium payments impeded enrollment. Knowing the reasons why families do not apply may enable the lead agency and CHP+ to ask policymakers for very specific changes to the program. Additionally, the lead agency operates the outreach and case management component of Medicaid's EPSDT benefit, so they have an established relationship with Medicaid.

Outreach Strategies Specific to Rural Areas

Throughout rural Colorado, public health nurses function as a medical safety net for the many areas without a physician. The work of public health nurses has been a key component in assisting families with CHP+ enrollment in rural and frontier areas. Nurses have publicized CHP+ by writing stories for local newspapers and assisting in developing media and marketing approaches for rural areas. Public health nurses have also contributed to outreach efforts through a Covering Kids pilot project in rural Prowers County.

Prowers County, located in southeastern Colorado, has a population of 13,800. Administered through the Prowers County Nursing Service, in collaboration with High Plains Community Health Center, the Prowers County project serves children through a local coalition of schools, parents, a community health center, the local nursing service, a child care program, a private insurance company, and a mental health center. The project's goal is to build a self-sustaining health system capitalizing on existing program and staff. The Nursing Service has long been active in promoting enrollment in children's health insurance and their outreach grant has allowed them to expand their outreach activities and to add two new employees.

Outreach activities include stationing an outreach worker at all community events, such as school registration, basketball games, and PTA meetings. Small businesses that do not insure their employees have also been targeted with a mass mailing. The Prowers staff has produced local public service announcements featuring school nurses, well known to local parents, who tell a true story illustrating the benefits of insurance for children. For example, one story described a child whose asthma improved after receiving regular health care while another described the financial benefits to a family whose child suffered a broken arm one week after enrolling in CHP+. Since it has been their experience that families who complete an application at home are unlikely to submit it, the nurses also assist families in filling out applications. Our contact also noted that nurses and families have established relationships based on respect, facilitating family trust.

Barriers to Effective Outreach

Outreach efforts in Prowers County have encountered unique barriers in the enrollment of children from farm families. Many farm families may be eligible for CHP+, but do not see themselves as possible eligibles because they have assets, such as farm equipment and animals. Applications for CHP+ and Medicaid require income to be reported as a wage, while the earnings of farm families typically include home accounts. The Farmer's Home Administration (FHA), which provides farming support, requires that families track their farm and home accounts jointly. Thus, families who follow the FHA requirement may experience difficulties in providing information as required on CHP+ and Medicaid applications.

Across our five counties, various providers described the CHP+ enrollment process as slow and complicated by documentation requirements. A respondent from the Garfield County Nursing Service was dissatisfied with the enrollment of CHP+ children, primarily as a result of cumbersome documentation requirements for birth certificate, income eligibility, and disclosure of assets. One outreach worker pointed out that income verification was difficult for employees paid on a weekly basis since they had to gather paystubs. However, a Custer County nurse said her patients are pleased with the coverage, while another nurse in Mesa County felt that patients valued CHP+ because it was not perceived as welfare. Providers are finding, however, that patients are having difficulties navigating the managed care system. They are unfamiliar with having a primary care physician and tend to delay care until there is an emergency.

Enrollment

The state's goal is to decrease the number of uninsured children with family income below 185 percent of poverty by 50 percent. Since implementation in April 1998, 19,000 children had enrolled in CHP+ as of August 1999, approximately 25 percent of the potentially eligible population. Among those enrolled, 7,000 children were participating through the CHP+ provider network. The state estimates that 4,000 of these children live in rural areas. The DHCPF had roughly calculated that, as of December 1998, 33 percent of those eligible for the CHP+ in rural areas were enrolled, in comparison to 11 percent of those eligible in urban areas. While these numbers indicate great success in enrolling children from rural areas, we were cautioned by the DHCPF that the original CCHP was specifically designed to target uninsured children in rural areas, which may inflate CHP+'s rural enrollment. In addition, the direction of the program in future years will likely concentrate more attention on urban areas because of greater urban poverty and uninsurance, so monitoring of enrollment by rural advocates may be appropriate.

Table 4 compares CHP+ enrollment between July 1998 and March 1999. While enrollment in the study counties has increased from 29 to 52 percent, the state as a whole has increased 72 percent. It appears that enrollment in rural counties may be progressing more slowly than the rest of the state. Across the state, significantly more children have applied for the program than have been enrolled. While 7,857 applicants were denied enrollment between July 1998 and March 1999, 2,860 were denied because they were eligible for Medicaid. The large number of applicants compared to enrollees may be a measure of perceived need for the program among lower income families.

Table 4
CHP+ Enrollment in Five Counties, July 1998 to March 1999

Counties of Interest	Total Enrollees July 1998	Total Enrollees March 1999	Percent Change
Custer	25	38	52%
Garfield	155	200	29%
La Plata	172	233	35%
Mesa	1,056	1,526	45%
Teller	55	79	44%
COLORADO	8,271	14,221	72%

Source: Colorado March Monthly Eligibility and Enrollment Report.

Rural Provider Participation Issues

Physicians and other providers expressed substantial frustration in dealing with CHP+ administration and reimbursement issues. One clinic and an independent pediatrician who participate in the CHP+ provider network felt that the capitation amount is too low, resulting in a financial loss. A family practitioner that runs an indigent clinic claimed that the capitated program made it so difficult to make ends meet that he would prefer to see patients on a pay-what-you-can basis. This physician also suggested that he preferred retirement to dealing with the state programs. The pediatrician also felt that paperwork was too extensive to be dealt with by the one receptionist/billing clerk in her clinic.

In Woodland Park, Teller County, only one of eight physicians accepts CHP+. Providers are frustrated by delays in reimbursement, which they say takes about four months. Several providers felt it would have been more efficient to expand coverage by expanding Medicaid, rather than by creating another bureaucracy. Two providers felt the organized infrastructure of an HMO made dealing with the bureaucracy of CHP+ easier.

The result of these frustrations is yet unknown. The University of Colorado Health Sciences Center had originally negotiated contracts with CHP+ physicians and turned this responsibility to DHCPF last year. The Department is currently recontracting with the physicians. In our interviews with the DHCPF, we found the Department willing to be flexible in contracting with physicians. The Department described CHP+ as designed to operate in a manner similar to commercial insurers so that if providers do not have a sufficient number of CHP+ enrollees to support a capitation arrangement, the Department can negotiate a separate fee-for-service contract.

The HMOs serving CHP+ must also serve Medicaid, though they may have different provider networks for each program. For example, Kaiser Permanente has a limited network serving Medicaid but a larger one serving CHP+. Physicians may elect

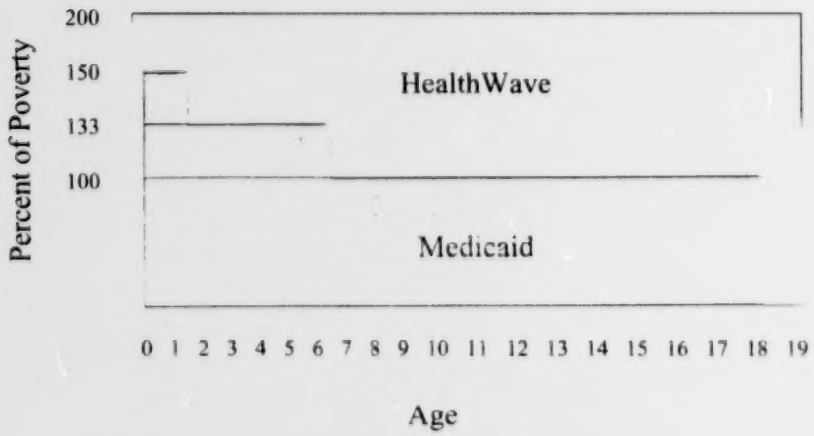
to serve CHP+ children without serving Medicaid. These arrangements could result in families seeking care from more than one provider if they have children in each of the two programs.

Public health nurses assume an important role in delivering care to rural areas. Though county nurses have historically been involved in delivering direct services such as well baby and child care and school nursing, they are only reimbursed under Medicaid if the patient is referred by a primary care physician for well-child services. Under CHP+, the nurses are not reimbursed. This seems to overlook provider shortages in rural areas and the importance of nurses to rural service delivery in Colorado.

Plan Overview

Kansas' HealthWave, a private, separate program, extends EPSDT-equivalent[23] coverage to children ineligible for Medicaid. HealthWave covers children from birth through age 19, from families with income up to 200 percent of the federal poverty level. This program compliments the graduated eligibility requirements of the Medicaid program and enhances the limited outpatient package formerly provided under the state's Caring Program.[24] Medicaid covers infants in families with income up to 150 percent of poverty, children from birth through five years of age in families with resources up to 133 percent of poverty, and children ages six through 17 in families with income up to 100 percent of poverty (Figure 2). Using CPS data, the state estimates that 60,000 children may be eligible for HealthWave.

Figure 2: KANSAS
Age and Income Eligibility Standards
for Children's Health Insurance Programs



HealthWave services have been provided since January 1, 1999. Though families are not charged copayments for physical health, behavioral health and substance abuse, and dental services, families with income over 150 percent of poverty are charged a monthly premium. Families with income between 151 and 175 percent of poverty pay

[23] Medicaid's EPSDT benefit includes screening, diagnosis, and treatment of physical and mental health problems and covers vision, dental, and hearing services.

[24] Children are ineligible for HealthWave if they had insurance within six months prior to their application that was terminated for the purpose of substituting HealthWave for previous coverage.

$10 a month; families with income between 176 and 200 percent of poverty pay $15 a month.

HealthWave's enabling legislation requires mandatory capitated managed care systems statewide, with fee-for-service payment allowed in extremely rare circumstances such as for hemophilia treatment and transplants. Though the state intended to offer families a choice of health plans where possible, implementation of managed care statewide has proven challenging. Statewide managed care does not exist for Medicaid or the public employees' insurance. Medicaid allows recipients to select between PCCM and HMO options. Two MCOs and one behavioral health plan have been chosen through a competitive bid to serve HealthWave.

Under HealthWave, Kansas is split into 3 regions, each with an equal number of targeted children. Region 1 includes the 23 eastern-most counties and is served by one HMO, Family Health Partners of Kansas City, Missouri. Region 2 includes western counties. Region 3 includes the southern part of the state, including Wichita and other, sparsely populated areas. Children living in regions 2 and 3 were formerly served by the same managed care plan, Horizon Health Plan, Inc. operated by the Kansas Medical Society. In April, the Medical Society sold its controlling interest in Horizon to a Kansas City, Missouri HMO called FirstGuard. One behavioral health plan serves the entire state.

The Kansas Department of Social and Rehabilitation Services (SRS) administers HealthWave. SRS also serves as the lead organization and fiscal manager for the state's Covering Kids grant, while the Kansas Children's Service League administers it. Two of three Covering Kids pilot programs operate in rural counties, each discussed below. As of December 1998, the Caring Program (CP) stopped accepting applications for health coverage. CP applicants are referred to HealthWave. Although CP has provided HealthWave with a list of their enrollees to contact for enrollment, it is not certain that all CP participants will be eligible. The CP staff is currently considering alternative efforts to insure other Kansans of limited incomes.

Annual utilization and review studies may be requested by the state from providers. Potential studies being considered by the state include examining access measures relevant to children in rural areas, monitoring provider numbers in each county, 24-hour accessibility, availability of transportation services, and distance and travel time between providers and consumers. The Kansas Office of Rural Health is interested in participating in the state's development of an evaluation mechanism to ensure that it focuses attention on children in rural areas as well as sub-populations of rural areas, such as children of farm workers.

Rural Outreach Strategies

Coordination with Medicaid and Administrative Simplification

Kansas has initiated several strategies to coordinate the HealthWave and Medicaid programs while simplifying Medicaid's administration. Kansas will develop a single application for Medicaid and HealthWave, and offer one-year continuous eligibility for both programs. In the next few years, HealthWave and Medicaid will become one program that differs only in its payment source.

The state will institute a toll-free hotline for information, to request an application, and provide automatic checks on eligibility for both programs. A central clearinghouse will process applications and determine eligibility for both programs. The clearinghouse will also assist with outreach.

Statewide Promotion

Outreach is a challenging issue for Kansas because they have two highly populated major cities surrounded by many sparsely populated counties. The population is concentrated at the eastern edge of the state, while the southeast and western parts of the state are very rural. State officials believe that typical media approaches, such as radio ads and billboards, normally employed by CHIP programs are less likely to work in its sparsely populated areas. The state's outreach contractor, Maximus, has hired ten outreach workers assigned to ten regions across the state. The goals of the outreach workers are to learn about their counties and tailor programs to meet their needs. Each outreach worker is expected to coordinate with community-based organizations because their staffs know the needs of the community and its children.

Marketed as a health insurance program, HealthWave will coordinate with other state and community agencies, including the Department of Education, local unified school districts, local health departments, the state Insurance Department, Indian Health Clinics, Head Start, school-based clinics, WIC, Kan Be Healthy,[25] Federally Qualified Health Centers (FQHCs), Title V, pre-schools, child care organizations, parent-teacher associations, religious organizations, and others. Applications will be available at a number of these sites. Public schools are the main outreach setting and CHIP information will be available at school registration. Special efforts will be made to contact families who apply for free or reduced price school lunch. Public service announcements and mail inserts in utility bills will also be used to publicize the program.

The Kansas Children's Service League, the state Covering Kids grantee, administers several statewide outreach initiatives that extend the activities of Maximus as well as provide outreach tailored to individual communities. The program intends to operate with a special focus on enrolling hard-to-reach children, such as migrants, the homeless, new state residents, and those who are home-schooled. A statewide

[25] Kan Be Healthy is the state's Medicaid EPSDT program.

coordinator, who began work on May 1, 1999, is in the process of recruiting 300 volunteers across the state to conduct outreach within their home communities. The staff anticipates that the volunteers will include those interested in children's health, such as program recipients. The volunteers will be provided with training, informational materials, and prepared presentation materials. A database will track their preferred methods for outreach, such as a preference for participating as a public speaker or providing one-on-one application assistance. In collaboration with Maximus, the Children's Service League will track the number of submitted applications resulting from Covering Kids activities, through a stamp on the application coded for state efforts and those of each pilot site. The Children's Service League has also developed brochures, videos, presentations, and a web site with links to coalition members' sites.

The Children's Service League will report to the state on the success of Covering Kids in enrolling children of various demographic characteristics. The exact method for evaluating their success is not firm. They have several questions they must answer for RWJF to evaluate their grant, so the League has created a special database where the state and pilot project staff can answer relevant questions on a monthly basis. They expect this will help them with reports to the state as well as to RWJF. In the future, the League expects to bring in an outside evaluator.

Outreach to the Native American Community

The Department of Social and Rehabilitation Services (SRS) is conducting semi-annual meetings with tribal leaders. SRS hosted a retreat in October 1998 for its policy staff and tribal social services organizations, where CHIP was a topic of discussion. The SRS also plans to include the names of community-based organizations serving Native American children in its HealthWave media campaign and other outreach activities. Enrollment of Native Americans in CHIP will be tracked through answers to an ethnicity question on the application.

Outreach Strategies Specific to Rural Areas

Mercy Health System of Kansas operates a Covering Kids pilot project in the rural southeast portion of the state. The project is located in two non-contiguous counties where Mercy has hospitals, Bourbon and Montgomery Counties. Mercy's basic approach is to enlist knowledgeable people to provide information and application assistance in places frequented by potential HealthWave eligibles, such as during health care visits and trips to department stores. Nurses and social workers are providing outreach and application assistance during maternal and infant home care and clinic visits. Project staff have found that many employees of the Mercy Health System are interested in HealthWave, particularly housekeeping staff and nurses aides.

A department store in Bourbon County hosted a children's health fair organized by Mercy in February. Representatives from Mercy, a mental health program, the police and fire departments, and WIC were featured. The fair had a large turnout and Mercy staff distributed 280 applications. The department store manager was very willing to

participate in the effort and many employees asked for information and applications. A retailer will host a second children's health fair in Montgomery County with many of the same types of organizations represented, including a fitness club for children.

In the coming months, Mercy will set up a booth at the Neewollah Festival, a fall event that attracts families from neighboring counties. Mercy is also recruiting volunteers; in fact, the hospitals' auxiliary is anxiously awaiting the opportunity to participate in the project. As many elderly attendees are expected, project staff hope to target the grandparents of eligible children. The area has a high rate of teen pregnancy and many grandparents assist in the care of their grandchildren. In the footsteps of an American Hospital Association effort in Tulsa, Mercy would also like to be able to review applications for completeness of information in order to facilitate the enrollment process before sending them to Maximus, but currently does not have the needed resources.

Our respondent felt that since Mercy represents the only hospital in Bourbon and one of two hospitals in Montgomery, they have excellent name recognition and an established relationship with the community. Mercy has hired a site coordinator from the area, a person who "knows everyone" and previously worked in public information for the maternal and infant home care program.

Mercy has found the Children's Service League to be supportive in providing and sometimes creating outreach materials that address the community's characteristics. They have also received an outreach kit from the Center on Budget and Policy Priorities in Washington, DC, with valuable references on rates of uninsurance and the need for CHIP, outreach ideas, and useful audiotapes and books from an RWJF grantee seminar.

The United Methodist Mexican-American Ministries, which operates a community health center with a social service/citizen assistance program, also has a Covering Kids pilot project in the rural southwest corner of the state. Though its pilot project does not officially start until July 1, a bilingual coordinator and assistant coordinator have been hired. The area served by the Ministries has a large immigrant population with as many as 19 different languages spoken at schools. Clearly, bilingual materials and staff are important. Outreach activities target families at school registration, hospital maternity wards, adult learning centers, community police substations, and through area employers. They are coordinating a HealthWave insert to appear in the pay envelopes of a local beef-packing plant.

Even though the Ministries has a large immigrant population, it does not expect to have a difficult time making clear to potential enrollees that the public charge issue does not apply to HealthWave. The Ministries has been in the community for 25 years and has an established relationship; they also have bilingual staff.

Barriers to Effective Outreach

Barriers to effective outreach include state and federal policies that have resulted in unexpected difficulties. The state's crowd-out policy has drawn criticism. "Crowd-out" occurs if the CHIP program encourages families to drop private coverage in order to obtain publicly-funded coverage. To deter crowd-out, children are deemed ineligible if their former coverage was voluntarily terminated within six months of their CHIP application. Many feel the policy penalizes families who actively seek to maintain insurance coverage for their children, but terminated coverage only when they could no longer afford the premium.

Barriers to effective outreach include the state's crowd out policy and the federal 10 percent limit on administrative funds, which includes funds that can be used to support outreach activities. Kansas has had difficulties obtaining funds for early outreach because the 10 percent limit is based on program expenditures. Because HealthWave was a new, separate program, high administrative start-up costs were necessary before expenditures could be directed to delivering care to enrollees.

Another barrier is consumers' association of HealthWave with welfare. Program staff is trying to communicate that both HealthWave and Medicaid are health care programs, not welfare. A related obstacle for the Mercy Health System pilot project is the automatic Medicaid screen for HealthWave applications. Families who applied for HealthWave have been surprised to receive a letter from the state informing them that their children have been enrolled in Medicaid. Until the time when both programs appear as one, applicants need good information letting them know they will also be screened for Medicaid. We also heard anecdotes that families who apply for HealthWave, but are found eligible for Medicaid, have withdrawn their applications. These families would rather pay the HealthWave premium than incur the welfare stigma.

One respondent noted that simply providing an application without assisting in its completion is not ideal. However, it may not be practical to provide one-on-one assistance to everyone and many people may not want this help. We also heard that some caseworkers have given conflicting and inaccurate information to applicants. This respondent noted the application appears to require the name and address of an absent parent, when in fact this is optional and does not affect eligibility. However, caseworkers reportedly have required this information and have also required parents' Social Security numbers even though only the child's Social Security number is needed.

The state's choice of Maximus to oversee outreach and enrollment activities has been criticized by rural advocates. With its headquarters in Virginia, Maximus may have little knowledge of the state's rural population. Also, the SRS relies heavily on schools and school principles to conduct outreach. One respondent felt that this overburdens already busy people who have no accountability to perform outreach. This respondent pointed out that the same may be true for other rural providers, none of whom have excess capacity to perform HealthWave outreach without being adequately compensated

for their efforts. The lack of funds devoted to outreach seems to signify a lack of willingness to truly enroll children in HealthWave.

The Kansas Association for the Medically Underserved, representing FQHCs, CHCs, and free clinics, currently employs an Americorp Promise Fellow to conduct outreach in the state's two major cities, Wichita and Topeka. The Association has applied for a grant to fund another Americorp Fellow to conduct outreach in rural areas.

Enrollment

One of state's strategic objectives is to provide HealthWave coverage to 30,000 children, half of the estimated eligible population, by December 31, 1999. Another 10,000 children will be enrolled in the two following years. As of June 1999, Kansas was well on its way to meeting this goal – over 11,000 children had been enrolled in HealthWave and 11,300 in Medicaid. The state decreased uninsurance among the HealthWave-eligible population by 18.3 percent. Among our five study counties, enrollment in HealthWave increased from 4 – 48 percent between June and October, with three counties keeping pace or exceeding the state's overall 24 percent increase. Cloud and Neosho counties have experienced only modest gains over the four-month period. Though our respondents noted that enrollment in rural areas is limited and much higher in the major cities, HealthWave has enrolled children in each of the state's 105 counties.

Table 5
HealthWave Enrollment in Five Counties, June - October 1999

County	June 1999	October 1999	Percent Change
Cloud	72	75	4%
Kingman	30	36	20
Marion	67	88	31
Neosho	127	132	4
Stafford	27	40	48
KANSAS	11,024	13,704	24

Source: Maximus Enrollment Report, June 1999

Rural Provider Participation Issues

We heard conflicting reports from providers serving HealthWave and Medicaid about their relationships with the programs. We are able to document several examples of provider resistance and provider support for HealthWave.

Concerns with Managed Care

Generally, we found that physicians dislike managed care across the state, with particular participation problems apparent in the southwest corner of the state. Our state contact felt that since rural physicians do not have to compete for patients, they have few incentives to join HealthWave provider networks. As a result, the HealthWave plans have had to be creative to ensure they meet the state's requirement that each enrollee is within 30 miles of a provider. Even though the plans are paid by the state on a capitated basis, most physicians in rural areas have negotiated fee-for-service reimbursement from the plans. One contact did not think any rural physicians were paid a capitated fee.

Our state contacts perceived providers as more interested in participating with HealthWave than Medicaid, even though payment is comparable across the two programs. However, we found some evidence that providers in the rural southwest are unwilling to participate in HealthWave. The United Methodist Mexican-American Ministries in the southwest corner of the state operates a community health center and has a Covering Kids pilot project grant. The staff expects to have more difficulties ensuring provider access than in enrolling children in their targeted counties of Finney, Ford, Grant, Haskell, Kearney, Morton, Seward, and Stanton. They will begin their outreach efforts by surveying area providers to determine who accepts HealthWave.[26] Few specialists and hospitals are participating in HealthWave because the program insures so few patients that it is not worthwhile for them to deal with another insurer. Since specialists will not affiliate with HealthWave, primary care providers also decline since they can not make referrals and can not be responsible for the full continuum of specialty care. The respondent describes the resulting lack of provider participation as unique to rural areas, since there are no options when the only provider in a county will not participate. Even the community health clinic run by the Mexican-American Ministries is not participating as a HealthWave provider because of the lack of specialists. They are, however, providing services for these children but are not being reimbursed.

We heard from our state contacts that providers in southwest Kansas have a particularly strong dislike for managed care, a dislike established long before implementation of HealthWave. This has significantly reduced provider participation in these counties, a problem that has not been encountered elsewhere. Providers are particularly concerned that they would not be able to continue their established referral patterns.

The Office of Rural Health told us they are concerned about the availability of Spanish-speaking providers, especially among the large and growing Hispanic population in rural areas served by the United Methodist Mexican-American Ministries. Potential language and cultural barriers to care may be especially significant in the areas they serve since their large immigrant population speaks as many as 19 languages.

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[26] The respondent for this pilot project told us the state data on participating providers are inaccurate so they need to collect the data on their own.

Provider Support

Most physicians in our selected counties generally perceived HealthWave positively and two were enthusiastic about the program's goals. One physician in Stafford County claimed he pressured his colleagues to participate in HealthWave and they are satisfied with the program. Physicians' office managers said that problems with reimbursements were no greater than those they encountered under Medicaid. The physicians felt that reimbursement was low, but given the fiscal realities of the state, it was better to cover these kids even at a low rate of reimbursement. A number of physicians remarked that some of their patients had been dropped from Medicaid and now had coverage under HealthWave and had returned to their practice. Physicians are somewhat less inclined to participate in Medicaid because they have been subjected to late payments, back payments, and adjustments to the state's overpayments.

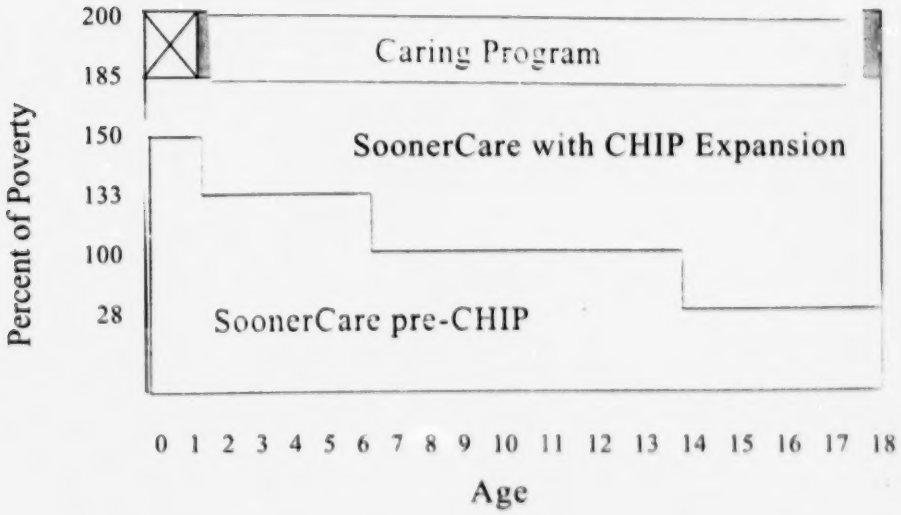
Availability of Dental Providers

Delta Dental, a managed care organization, provides dental coverage in the two western regions in the state. Delta was able to bring approximately 450 (80 percent) of their dental providers into HealthWave. This high participation rate may be due to the fact that Delta pays 80 percent of the usual and customary rate (UCR). In contrast only a quarter of Kansas dentists participate in Medicaid, which pays 50-60 percent of the UCR. In the eastern part of the state, which includes Kansas City, Doral Dentist was awarded the CHIP contract, but only has about 35 providers currently participating.

Plan Overview

Using CHIP funding, Oklahoma expanded its Medicaid program, SoonerCare. SoonerCare will potentially insure nearly 95,000 Oklahoma children. Four months after federal passage of CHIP, Oklahoma raised its eligibility guidelines to serve children through age 17, from families with income under 185 percent of poverty (Figure 3).

Figure 3: OKLAHOMA
Age and Income Eligibility Standards
for Children's Health Insurance Programs



The Oklahoma Health Care Authority (OHCA) administers SoonerCare. Other parties concerned with CHIP in Oklahoma include the Caring Program, the Covering Kid's state and pilot program grantees, as well as other state and local organizations providing social services to children and their families. The state's Caring Program (CP) witnessed a significant enrollment decline as a result of the SoonerCare standards. In response, CP set new standards as of March 1, 1999 to include children from age one (not birth) through age 17, from families with income between 185 to 200 percent of poverty.

SoonerCare is a managed care system designed to serve Medicaid recipients in urban and rural areas. It is, in fact, two programs – SoonerCare Plus and SoonerCare Choice. Comprehensive services, including behavioral health, are fully capitated to urban beneficiaries under SoonerCare Plus. Primary care office visits, case management,

and diagnostic and ancillary services are provided to rural beneficiaries through a partially capitated arrangement under SoonerCare Choice. There are no cost-sharing requirements. In the SoonerCare Choice enrollment process, beneficiaries select a primary care physician (PCP) from the Choice Provider Network, rather than selecting an HMO (as under Plus). Beneficiaries are encouraged to select a PCP within 45 miles of their home and within 14 days of their application or they are autoassigned to a provider within 45 miles. If no provider is available within 45 miles, the beneficiary remains in the fee-for-service Medicaid program. The state claims that this practice works well with most beneficiaries who select a provider within a shorter distance. Benova, Inc., has been contracted to operate a telephone hotline and provide enrollment services.

The Covering Kids program is perceived as instrumental in assisting the DHS outreach workers in planning and managing local events and programs. There appears to be a strong partnership between the OHCA, the Department of Human Services, and Oklahoma Institute for Child Advocacy, the lead organization for Covering Kids. The state agency is part of the Covering Kids state coalition and the coalition has provided a rich format for discussion of enrollment problems and potential solutions. For example, the coalition discovered that families who had applied using Spanish-language applications were receiving English-language enrollment packets.

One of the state's strategic objectives is relevant to rural areas. The state intends to ensure that participation percentages are the same for both the urban and rural SoonerCare programs. The state will also monitor rural and urban autoassignment rates in attempts to ensure that autoassignment is less than 50 percent by the end of FY 1998 and less than 40 percent by FY 1999.

Rural Outreach Strategies

Administrative Simplification

The state has taken several steps to simplify the Medicaid application process. The Medicaid application was abbreviated to a one-page, two-sided form from its original 16 pages. The assets test and in-person interviews were eliminated, with estimated annual savings of $2.2 million in administrative costs. A toll-free telephone help-line assists applicants with enrollment and with selection of a health plan and provider.

Statewide Promotion

As part of the state's eligibility expansion, a Medicaid marketing and outreach campaign was initiated for the first time. These activities focus on written and broadcast materials. Written materials, prepared at appropriate reading levels, include flyers, brochures, posters, and a generic press release that can be adapted for use by county personnel. The state has contracted with the Oklahoma Association of Broadcasters to air 30-second announcements on television and radio, and they are looking into statewide

outdoor and newspaper advertising. All outreach materials will be translated into Spanish and advertising time is being sought on a Latino radio show.

Local Dissemination

The state intends to disseminate information through direct mail; community events; WIC, food stamps, and Head Start programs; health care providers statewide; child support programs; local United Ways offices; employers of the working poor; local Chambers of Commerce and governments; and churches and the religious community. The state has hired 47 outreach workers to identify and enroll SoonerCare eligibles. After a two-week training period, the outreach workers are charged with designing and developing programs that meet the specific needs of one or more counties. While each outreach worker plans their own programs, the state anticipates activities such as providing information through schools, health departments, health fairs, and grocery stores. The outreach workers are also collaborating with the state's "Children First" program – a home visiting program for families of newborns that meet specific income requirements – to provide SoonerCare applications during home visits.

Outreach Strategies Specific to Rural Areas

We conducted interviews with four outreach workers serving our rural counties of interest. These workers identified the school system as a basic contact point for all children. Schools providing Medicaid-covered services, such as special education and transportation, have been very interested in working with the outreach workers to enroll eligible children and claim reimbursement. Through the spring, the outreach worker for Custer County will attend registrations for pre-kindergarten and kindergarten programs. In one town, Medicaid applications were sent to all children pre-kindergarten through grade 6, resulting in 200 new enrollees. In another rural area, the outreach worker is coordinating with the special education director to determine how applications can be mailed to all students (regardless of special education status). This approach is especially important for enrolling adolescents since parents have few opportunities to come to school. We also heard from the OHCA that some outreach workers enlisted the assistance of school secretaries, who often had regular contact in and outside of school with potentially eligible children and their families.

The outreach workers have found providers to be active participants in SoonerCare enrollment activities. Physicians asked one outreach worker to summarize the program's income guidelines in response to many patient questions about Medicaid eligibility. The outreach worker responded by preparing a clear fact sheet describing eligibility and the application process, supplemented with SoonerCare pamphlets. At a pediatrician's office, the outreach worker noticed that her fact sheet was taped to the reception glass with the relevant income standards highlighted; she describes providers as thrilled to have the information, having found this hard to obtain in the past. The outreach worker for Mayes County makes weekly visits to an IHS clinic during obstetric and walk-in hours, approaching patients about the program and assisting them with the application. She also visits Head Start Centers. Another outreach worker visits the

maternity ward of a hospital and assists new mothers in completing the application for their newborns.

Employers paying minimum wage have also been targeted. A local meat packing company and major employer in Custer County, pays minimum wage and is likely to have many potentially eligible children among its employees. The company's caseworker, who helps employees access services generally, will work with the outreach worker to enroll eligible children. Nursing homes have also been very receptive in promoting SoonerCare to employees since they do not offer dependent coverage. Agricultural jobs are also an important source of employment in Custer, though few applications have come in from these families.

Other strategies include developing partnerships with agencies concerned with children and families such as community action agencies (which operate Head Start in Oklahoma), health departments, hospitals, churches, businesses, and other organizations. The outreach worker for both Johnston and Love Counties presents information on SoonerCare to each agency and provides training in application assistance. This outreach worker sought and received the cooperation of local newspapers and cable stations in running advertisements.

One of the three RWJF Covering Kids pilot projects in Oklahoma, the South Central Consortium, serves five rural counties including Love County. The five-county area is home to a large Native American population. The grantee anticipates needing a different approach for this population since they already have a health system in place but are eligible for SoonerCare benefits.

A major theme of our interviews is that outreach workers conduct their activities at the places families frequent. In addition to schools, providers, and employers, other examples include high school basketball and football games, a weekend health fair at a local department store, radio spots to target those with low reading skills, presentations to churches during Sunday services, and a bulletin in church newsletters about the program.

Barriers to Effective Outreach

The many names that relate to SoonerCare are confusing to potential beneficiaries. The public has very concrete definitions of the word Medicaid and also may be confused about the difference between CHIP, SoonerCare Choice, and SoonerCare Plus.

Repeatedly we heard that potential enrollees are unaware of the benefits of health insurance, that they may qualify under the revised eligibility standards, and that they may perceive the program as welfare. Many potential beneficiaries are unaware of the importance of accessing health care services unless they are in an emergency situation. More pressing needs, such as providing food and shelter for a family, take precedence over health insurance. Due to the changes in income eligibility, families without any

experience or knowledge of Medicaid are now eligible. One respondent noted that working families at relatively higher income levels do not expect to qualify for Medicaid. These families may still associate Medicaid and welfare assistance and often are reluctant to identify themselves with a welfare program. We heard that food stamp recipients may wait until midnight to do their grocery shopping so their neighbors will not see their form of payment, an extreme example of this concern. A parent told an outreach worker that she did not want people telling her how to handle her child's health care. One outreach worker tries to counter suspiciousness of government programs with a discussion of health insurance, its relationship to access to care, and how age-appropriate care affects child development and school achievement.

The outreach workers identified several barriers to enrollment for minority populations. Until recent clarification, neither HCFA nor the Immigration and Naturalization Service had ruled on whether immigrant children could participate in CHIP without jeopardizing their status. As a result, immigrant families have hesitated to enroll. At a health fair, a number of other potential applicants expressed concern that if their name appeared on a benefits application they would be reported to immigration offices. Prior to a new six-month eligibility review procedure, one outreach worker found that a large share of disenrollments were for Spanish–speaking families. Providers at Indian Health Clinics in Love County have reportedly misinformed their patients that they are not eligible for SoonerCare and may not receive services outside IHS clinics. Many Native Americans in this county would like another source of insurance coverage since IHS clinics are only open during business hours and do not provide emergency services.

Enrollment

In its annual report to HCFA, the state reported that it nearly reached its goal of enrolling 45 percent of the 40,995 CHIP eligible children. Oklahoma enrolled 17,521 children, or 43 percent of the eligible population, between December 1, 1997 and September 30, 1998 (the portion of the federal fiscal year 1998 in which CHIP was operating). Another 27,000 have been enrolled in traditional Medicaid. During February and March of 1999, the state witnessed a spike in rural enrollment. Enrollment in SoonerCare Choice (the rural model) increased by 9,803 new enrollees, and 6,665 enrollees in SoonerCare Plus (the urban model). The Oklahoma Health Care Authority is uncertain as to the exact reason for this spike, but attributes some success to the inventive efforts of its county outreach workers. Table 6, below, presents enrollment data for the five rural counties of our study.

Table 6
SoonerCare Enrollment for Five Counties, February 1999[27]

Counties	Children under 18 below 185% FPL	Enrollees as of 11/1/97	Enrollees as of February 1999 (percent change)
Custer	3,214	968	1,222 (+26)
Garvin	3,184	1,205	1,440 (+20)
Johnston	1,315	677	869 (+28)
Love	1,060	365	433 (+19)
Mayes	4,671	1,476	1,926 (+30)
OKLAHOMA	412,201	146,597	181,492 (+24)

Source: Oklahoma Health Care Authority: State Baseline Estimates of Eligibles, June 29, 1999.

The state has met its goal in reducing rural and urban autoassignment rates to less than 50 percent by the end of FY 1998. Its 1998 Annual CHIP Report describes autoassignment in SoonerCare Choice as between 40-46 percent and SoonerCare Plus as between 50-56 percent. However, the state is concerned that the majority of its uninsured children (63 percent) are eligible for traditional Medicaid rather than CHIP, meaning that the state does not receive the enhanced payment rate. It has recommended to HCFA to allow the enhanced rate when CHIP outreach results in Medicaid enrollment.

Rural Provider Participation Issues

It appears that SoonerCare will have some difficulty in assuring access to medical and dental services to children in rural areas. Though several providers welcomed the enrollment of eligible children into SoonerCare as a means to increase the number of paying patients, providers' concerns about the program – its administration, reliance on managed care, and reimbursement rates – have affected their willingness to participate.

Concerns with Medicaid Administration

OHCA contracts with over 500 primary care physicians to deliver services to rural beneficiaries under SoonerCare Choice. From our interviews, we learned that OHCA constantly recruits providers but has not enhanced these efforts since the expansion in

[27] The state is using Census data, estimates from the Urban Institute, and estimates from the state Department of Commerce to determine the number of new and current Medicaid eligibles. The state is concerned that the CPS does not accurately capture its uninsured population. Specifically, the state is concerned that CPS sampling is conducted in limited areas and that it does not capture coverage under special state-funded programs or the IHS, undercounts Medicaid, has inconsistent responses to multiple questions, and may only reflect estimates at the time of interview rather than during the previous year.

December 1997. The state claims a steady increase in the number of providers over the last three years, with 75 percent of physicians electing to re-contract with the program. Shown in Table 7, three of five counties were unchanged in the number of physicians, while Custer increased by four physicians and Garvin by one physician. With the recent addition of four new physicians to Custer County, a respondent told us there is an increased competition for patients and physicians are now willing participate in SoonerCare.

Table 7
Population and Number of Physicians in Five Counties, 1999

Counties	Number of SoonerCare Physicians (change from previous year)	Number of Physician Assistants (change from previous year)	Number of Certified Nurse Practitioners (change from previous year)
Custer	7 (+4)	0 (-3)	0 (same)
Garvin	5 (+1)	3 (same)	1 (+1)
Johnston	1 (same)	0 (same)	1 (+1)
Love	3 (same)	0 (same)	0 (same)
Mayes	4 (same)	0 (same)	1 (+1)

Source: OHCA, 1999

The state has unsuccessfully attempted to contract with IHS providers. The state claims that some IHS providers did not want to care for non-Native American patients and others did not like the agreement SoonerCare had proposed. The state is currently preparing another contract.

While a few of the providers we spoke with seemed relatively satisfied with SoonerCare, others voiced significant concerns with the program and registered limited willingness to participate. One physician was frustrated by denials, auto enrollment, and the extent of information required for submitting claims. Auto enrollment was seen as a problem because it may bypass an established patient-physician relationship. This physician said that several of his colleagues would not accept re-assignment with the program. Providers were also concerned that patients had been assigned to providers not located in proximity to their homes, while passing over more closely located providers.

Other providers were concerned with the effect of a re-application policy on their ability to provide care. Previously, beneficiaries were responsible for submitting a reapplication for Medicaid at the end of each six-month eligibility period; however, many did not reapply and were disenrolled. Once they reapplied, several months might have passed. Providers were worried that patients might have gone without needed services or have been re-assigned to another physician, interrupting the existing patient-physician relationship. As of January 31, 1999 the state implemented a notification and renewal

procedure one-month before the end of an eligibility period. A beneficiary simply completes and returns a renewal application to DHS and there is no break in eligibility status. Providers were still concerned about this issue at the time of our interviews in March 1999, indicating they had not yet felt the effect of this change.

Concerns with Managed Care and Reimbursement

From the state perspective, rural providers had little experience with managed care and were concerned that it would severely reduce their reimbursements. The state believes this apprehension has diminished over time, with growing recognition among physicians that a primary care model is a more moderate form of managed care than full capitation.

However, we repeatedly heard that providers around the state refuse to participate in SoonerCare because of managed care, especially in rural areas. One interviewee suggested that urban providers also do not like managed care, but they accept it. When SoonerCare went into effect in 1996, 13 out of 14 physicians in rural Ottawa County stopped seeing Medicaid patients because they did not want to participate in managed care. The one remaining physician stopped seeing SoonerCare patients as of April 1999, because of administrative difficulties and inadequate reimbursement. Other providers noted that reimbursement often does not cover overhead costs. Two physicians in Mayes County, currently served by four physicians, will not accept SoonerCare patients because of low reimbursement rates. Because so few physicians participate in Garvin County, many new SoonerCare enrollees have returned to the local health department for well baby care and immunizations, according to a respondent from the County's Health Department.

Availability of Dentists

The few dentists of Custer County have more than enough patients and are less inclined to serve Medicaid patients. In Ottawa County, one contact described a difficult situation for children in need of dental services – the only dentist who sees SoonerCare children is 100 miles away in Tulsa.

Over the years, the Oklahoma Medicaid program has witnessed a progressive decline in participation by dentists. In 1987, an estimated 1,021 dentists participated; by 1998, only 171 participated, a drop that has been particularly acute since Sooner Care began.[28] As of 1999, 208 in-state dentists and 16 out-of-state dentists contract with SoonerCare. Substantially more dentists, approximately 500, participate in the Dental Association's D-Dent program offering free dental services. A respondent from the Oklahoma Dental Association said the main problem with SoonerCare is reimbursement. Dentists are paid only half of their traditional fee and, since 65 percent of their fee is overhead, they are not able to cover costs by treating enrollees. Another respondent at the Dental Association reported that HCFA would soon document the dental program as

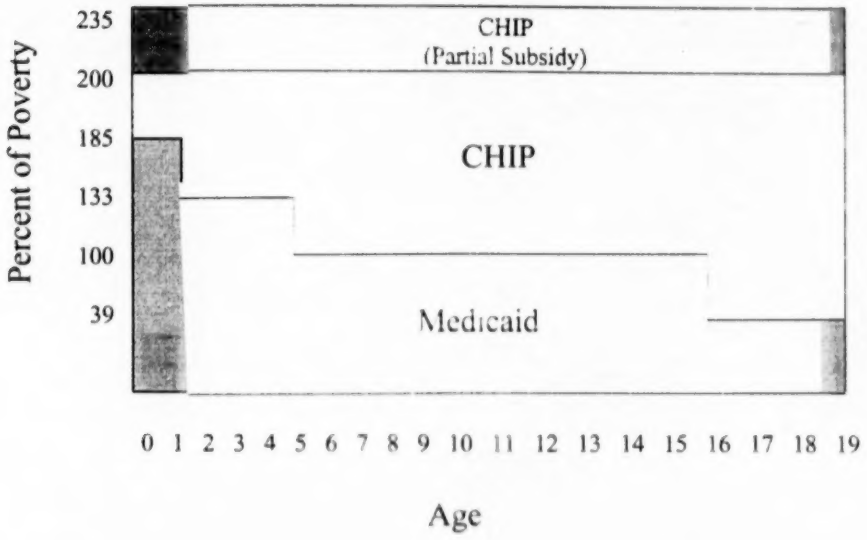
[28] Estimates provided by the Oklahoma Dental Association.

out of compliance with the EPSDT requirement that 80 percent of eligible children see a dentist annually.

Plan Overview

Continuing its long-standing Children's Health Insurance Program (CHIP), Pennsylvania selected a separate program for insuring children under Title XXI. Under the new program, CHIP eligibility has been expanded to children at birth through age 18, for non-Medicaid families with income at or below 200 percent of poverty (see Figure 4). Subsidies for half the premium, funded solely by the state, are also expanded to children through age 18 in families with incomes between 200 and 235 percent of poverty. The program expects to serve 100,000 new children under Title XXI in the unsubsidized program and another 22,000 in the subsidized program.[29]

Figure 4: PENNSYLVANIA
Age and Income Eligibility Standards
for Children's Health Insurance Programs



CHIP is operated through the state Department of Insurance, with the assistance of the CHIP Advisory Council on outreach and accessibility of services. Pennsylvania Partnerships for Children, an advocacy group, serves as the state's Covering Kids lead organization.

[29] Pennsylvania Department of Health: Ridge Budget Proposes CHIP Expansion to Provide Health Coverage to Uninsured Children. Press Release. February 3, 1998.

Prior to passage of Title XXI, the Caring Program (CP) provided insurance to children who did not qualify for CHIP or Medicaid with family income up to 235 percent of poverty. Under CHIP's expansion, it now covers the children CP once served, with CP redefining its insurance product to cover higher income families.[30] With coordinated eligibility standards and benefit packages across the two programs, the transition to CHIP simply involved a change in group number on recipients' insurance cards. Most families were unaware of the transition and may not have known whether their children had been enrolled in CHIP or the Caring Program.

The Department of Insurance contracts with five managed care organizations to administer CHIP across the state, known as "contractors." Four of these are Blue Cross and Blue Shield (BC/BS) networks, participating through their Caring Foundations;[31] Aetna US Healthcare is the remaining contractor. Three of the five contractors serve both Medicaid and CHIP children. For example, Independence BC/BS operates a separate, Medicaid-only plan and serves CHIP children through its Caring Foundation and Highmark BC/BS serves Medicaid, while its Caring Foundation serves CHIP. The same insurer operates for the two groups, but the children are served by different plans and, in some cases, a different panel of providers. CHIP network physicians are not required to accept Medicaid patients, though many do. Indemnity products serve children who do not have access to managed care; however, this effects less than five percent of all CHIP children.

CHIP benefits include primary and preventive care; physician and clinic visits; prescription drugs; diagnostic services; surgical services; inpatient and outpatient services; inpatient and limited outpatient mental health; durable medical equipment; home and community based health care; nursing care; case management; physical therapy, occupational therapy and services for persons with speech, hearing, and language disorders; vision; hearing; dental; and medical transportation. The only cost-sharing mechanism, a $5 copayment for prescription drugs, has been eliminated.

One of the state's five strategic objectives under CHIP is to improve access to coverage for children in rural areas, specifically among children in northeast and central Pennsylvania. A complimentary performance goal seeks to establish a relationship with the Center for Rural Pennsylvania, a non-profit organization concerned with rural public policy issues, to assist the state in identifying and eliminating barriers to coverage in northeast and central Pennsylvania.

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[30] As part of its new role, CP created a direct pay insurance program for families with income up to 300 percent of poverty, a group with a high rate of uninsurance. CP has also conducted fundraising to help families pay their portion of the premium in the subsidized portion of CHIP. CP also operates an educational program promoting immunizations and preventive care through brochures, pamphlets, an immunization record, and videos, offered in cooperation with providers. Their materials feature Mr. Rodgers and members of the Pittsburgh Steelers football team.

[31] There are four Caring Foundations: Western Pennsylvania Caring Foundation, Caring Foundation of Northeastern Pennsylvania, Caring Foundation of Central Pennsylvania, and the Southeastern Caring Foundation for Children. We interviewed the Caring Program associated with the Western Pennsylvania Caring Foundation; the activities underway at other Foundations and their respective Caring Programs differ.

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Efforts to monitor CHIP do not focus specifically on enrollment of children living in rural areas. Indirectly, rural enrollment is assessed with annual contractor reports on the actual and cumulative numbers of children enrolled *by county*. CHIP collects quarterly and annual information about enrollment, demographic and ethnic characteristics, outreach efforts, use of medical and dental services, member grievances, and data on financial expenditures. The Department of Insurance told us that the contractors have conducted satisfaction surveys of family members who are reportedly very pleased with the program and have suggested expanded benefits as an area for improvement.

Rural Outreach Strategies

Coordination with Medicaid and Administrative Simplification

In our earlier report, we found children's advocates critical of CHIP outreach strategies. They reported that parents and Medicaid eligibility workers were unaware of CHIP and that families denied Medicaid coverage were not referred to CHIP. One of our contacts alluded to this problem, saying that the enrollment procedures of Pennsylvania's CHIP and Medicaid programs were not well coordinated. Medicaid is currently adopting or will adopt several CHIP enrollment procedures. The state has begun work on a simplified, joint application for the programs after observing that very few ineligible families were mistakenly enrolled in CHIP through its simplified application. The Department of Insurance, the Medicaid Bureau, the five contractors, and other advocates including the state's Covering Kids grantee have worked together to develop the joint CHIP and Medicaid application. Our Covering Kids respondent described this effort as the most collaborative effort that she has seen, with many perspectives represented.

The joint application is expected to be ready in July 1999. Within the context of welfare reform's emphasis on work, Medicaid instituted mail-in applications so families would not need to take a day off from work to apply for benefits. Additionally, the state has instituted interagency agreements, memoranda of understanding, and other cooperative efforts to coordinate the efforts of CHIP and Medicaid. When CHIP contractors get a potential Medicaid applicant, they send the application to the Medicaid office so the family does not need to submit a separate application to Medicaid. (This also works in the reverse – Medicaid sends applications of potential CHIP eligibles to CHIP administration.) CHIP also offers 12 months of continuous eligibility, with annual recertification on their anniversary date. Resource eligibility requirements are not considered as part of income eligibility.

Statewide Efforts

Pennsylvania established outreach efforts through their pre-Title XXI program and has supplemented these activities under CHIP funding. CHIP contractors have the primary responsibility for outreach and the state has used its 10-percent funds to enhance

these efforts. The contractors use bilingual media approaches and advertisements in public places, such as buses and movie theaters. Each contractor has an outreach coordinator, who conducts outreach activities at health fairs, schools, and community events. The state plan requires contractors to increase outreach focus on community-based agencies in predominantly minority, non-English speaking areas. The Department of Insurance plans to work in consultation with other state agencies and the contractors to develop an outreach plan that includes provisions for reaching special populations. These populations include children in rural areas and inner cities, minority children, non-English speaking children, and children with disabilities. These efforts are to be coordinated with other statewide outreach techniques.

The state has developed a statewide media contract to air television ads promoting their 1-800 helpline. Staff feel this effort works because the helpline receives a large volume of calls after each ad airs. Staff from the Governor's office has presented information on CHIP to a group that meets on a quarterly basis to discuss issues of concern to rural communities.

Outreach Strategies Specific to Rural Areas

We found that outreach efforts in rural communities focus on gathering the support and enrollment assistance of local agencies serving children and families. Cornerstone Care, a network of three community health clinics, operates a Covering Kids pilot project across three rural counties in southwestern Pennsylvania, bordered by West Virginia on two sides. These counties include Green County, selected for study, as well as Fayette and Washington Counties. A coalition in each county, created to promote local ownership of CHIP outreach, guides and participates in outreach activities. The program has received the support and endorsement of each coalition member, including Head Start, local school districts, faith organizations, United Cerebral Palsy county agencies, WIC, family centers, local management agencies,[32] food banks, and other social service organizations as well as hospitals and health care providers. The coalitions specifically sought the membership of the Chamber of Commerce to target employers who do not provide employee or dependent health insurance. Interestingly, high school athletic directors are also participating in the coalitions because their student athletes are required to have health insurance in order to participate in high school athletic programs. Pilot project representatives are hopeful that this strategy will target typically hard to reach adolescents.

Coalition members also assist with CHIP enrollment. For example, if a WIC intake worker assisting an applicant finds the family's income in the range eligible for CHIP, he or she also assists the family in completing a CHIP application. Providers with Cornerstone Care also assist with enrollment at the point of care. The program had only been in operation for three weeks when we spoke with them in April 1999. They had completed their first campaign, targeting families at kindergarten registration.

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[32] Local management agencies provide subsidized day care for families with income below 185 percent of poverty.

Barriers to Effective Outreach

Our respondents identified several potential barriers to enrollment of eligible families, including lack of knowledge, confusion with new and past initiatives, and anticipated negative opinion of Medicaid. With CHIP income guidelines now at 235 percent of poverty, relatively higher-income families may be unaware of potential CHIP eligibility simply because they have not been the focus of older public programs. The public may also think an enrollment cap from 1997 is still in effect.

The joint application for CHIP and Medicaid and the requirement that CHIP applicants be screened for Medicaid may adversely affect families who have a poor opinion of Medicaid or perceive a welfare stigma. While contacts at the state level believe the selection of a separate, non-Medicaid program to be advantageous for families resistant to "welfare" programs, one of the primary outreach concerns of Cornerstone Care is dealing with families' resistance to government-sponsored programs. The population served by this Covering Kids grantee has a great deal of pride in their self-sufficiency. Though not universal, early feedback from several families indicates they will not participate in a government program. This aspect makes the pilot project different from the other projects in the urban areas of Philadelphia and Pittsburgh. The state's lead organization of Covering Kids, Pennsylvania Partnerships for Children, will conduct focus groups with families in the pilot counties to understand how they seek care when their children are sick, examine impediments to enrollment, and determine family experiences when they choose to enroll in CHIP. The statewide project director notes that perceptions of staff are likely to be very different from families and barriers may well be something they are unaware of.

Our respondents noted that families' daily concerns may not include health insurance. Families with healthy children who are getting by day-to-day do not consider health insurance a priority. The Cornerstone Care project counters this with the message that health insurance can spare them long term financial difficulties in the event of illness or injury. In fact, this message forms the basis of their community-wide outreach message on the importance of health insurance. County commissioners issued a statement to this effect. Other families think the program sounds too good to be true. Respondents believe that these families need the program to be endorsed by their family, friends, and relatives, or others they can trust, before applying.

Families are currently exposed to a number of messages from CHIP and Medicaid. As the state moves to mandatory Medicaid managed care by July (called "Health Choices") in its southwestern rural counties, beneficiaries and potential applicants are being bombarded with several messages about this new program. Adding CHIP to the mix of messages may only serve to confuse potential applicants.

Enrollment

As mentioned earlier, CHIP had 74,746 enrollees as of April 1, 1999, an estimated increase of 21,000 children since 1997. Table 8 illustrates enrollment in our

selected counties over six months. Enrollment in our selected rural counties has increased as fast as the state as a whole. Three of our counties in the central and northeast -- Bradford, Clinton, and Monroe -- increased enrollment by nearly 30 percent or more, compared to a 12 percent increase across the state as whole. These three counties seemed to meet the state's stated objective of increasing access to coverage for children in rural areas, specifically those in the central and northeast Pennsylvania. Enrollment in the remaining two counties, Adams and Greene, kept pace with state enrollment overall. However, an analysis of enrollment duration in CHIP found that children from rural areas remained in the program for a shorter time than children from urban areas.[33]

Table 8
Pennsylvania CHIP Enrollment in Five Counties,
September 1998 to March 1999

County	September 1998	March 1999	Percent Change
Adams	376	412	10%
Bradford	210	293	40%
Clinton	92	125	36%
Greene	340	379	12%
Monroe	688	877	28%
PENNSYLVANIA	65,578	73,158	12%

Source: Pennsylvania Insurance Department

Rural Provider Participation Issues

Contractor Issues

Though the Department of Insurance had little information available on the program's relationship with providers, other state sources described difficulties experienced by some contractors in contracting with rural providers even though providers support the goals of CHIP. One respondent heard an allegation that a contractor with an inadequate number of providers had impaired access to care in some counties. Aetna is said to have good provider participation in the Philadelphia area (in the east), but less so in the Western parts of the state. The Blue Cross/Blue Shield plans may have better rapport with physicians simply because they have been in operation longer and have better name recognition than Aetna (the sole non-BC/BS contractor). The problem appears to be the contractors' relationship with providers rather than providers' relationship with CHIP. As we learned in our previous report, CHIP had begun a move toward more managed care and perhaps providers are reluctant to join managed care plans.

[33] Lin CJ, Lave JR: Duration in and pattern of utilization under children's health insurance programs. *Health Care Financing Review*. 19(4):101-116, 1998

Provider Support for CHIP

Most physicians we spoke with in our selected counties expressed support for CHIP and the improvements in access to care it has made for their patients. A pediatrician in Clinton County believes he is providing more preventive care to more families who would not have received those services without CHIP. In Adams County, a pediatrician told us that CHIP makes it possible for migrants who remain in the county to access health insurance. Satisfaction with CHIP was especially high among physicians in group practices.

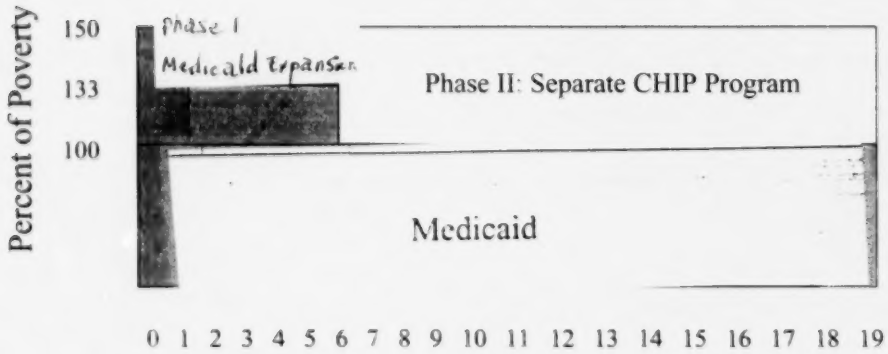
Reimbursement Concerns

Providers receive a smaller payment for serving CHIP children than Medicaid children. As one physician says, "we lose financially and we just hope we don't get too many CHIP patients." The state is expecting to address the difference in reimbursement across the two programs. Physicians felt that the current level of reimbursement does not support the provision of thorough and comprehensive medical assessments in well-child health care. For example, reimbursement is the same whether a physician conducts a full assessment of the child lasting over 30 minutes, or sees the child for an acute visit lasting 15 minutes. Some physicians feel they would receive a higher fee if the program were paid on a fee-for-service basis. One pediatrician saw the lack of payment distinction between pediatricians and family practitioners as a problem, because pediatricians have more specialized training in child health yet are paid the same as family practitioners.

Plan Overview

West Virginia's two-phased approach to CHIP expands coverage to children who were previously ineligible for Medicaid, or received limited benefits under the state's other insurance programs. Phase I, federally approved on September 15, 1998, expands Medicaid coverage to children between age one and five whose family income is less than or equal to 150 percent of poverty. Phase II, granted federal approval on March 19, 1999, is a private program administered by the state Public Employees Insurance Agency (PEIA). Eligible children include ages six through 18 from families with income at or below 150 percent of poverty (Figure 5). An estimated 1,741 children are potentially eligible for Phase I, while 22,901 may be eligible for Phase II.

Figure 5: WEST VIRGINIA
Age and Income Eligibility Standards
for the Children's Health Insurance Program



A number of state-wide and community organizations actively contribute to West Virginia's CHIP programs. Both phases of the program are designed and managed by the Children's Health Policy Board, located within the Department of Health and Human Resources (DHHR). Board members include the director of PEIA, the secretary of DHHR, a representative of children's interests, a certified public accountant, three persons experienced in employee or group benefit programs, and two state legislators. As noted previously, PEIA administers Phase II, while Mountain State Blue Cross/Blue Shield provides claims processing. The Healthy Kids Coalition, the state's Covering Kids grantee, and its pilot programs extend the state's outreach and enrollment efforts.

While Phase I enrollees receive access to comprehensive services through Medicaid, Phase II enrollees also have access to a wide range of benefits based on those offered to state employees. These benefits include: inpatient and outpatient services; physician services; surgical services; clinic services; prescription drugs; laboratory and radiology services; prenatal and family planning services; limited inpatient and outpatient mental health services and substance abuse services; durable medical equipment and other medical devices and supplies; home and community-based care; dental services; case management; habilitative and rehabilitative therapies; hospice care; and emergency transportation. There are no cost-sharing requirements. Though benefits between the two Phases are similar, Phase II does not cover enabling services, such as transportation, which are covered under Phase I.

The state elected to expand Medicaid for Phase I simply to get the program operating quickly. In the next legislative session, a proposal to combine Phases I and II into one private program may be proposed. As of June 1998, the Medicaid program had three mandatory managed care plans serving several counties along the state's western Pennsylvania border and the two counties in and around its capital city, Charleston. One mandatory primary care case management program serves the entire state.[34] PEIA offers fee-for-service benefits to Phase II children. The PEIA provider network is required to include community health facilities, such as primary care centers and school based health centers.

Children eligible for other programs providing limited health coverage are likely to be eligible for CHIP. CHIP-eligible children served by the Pediatric Health Services (PHS) program have received an informational letter encouraging their enrollment in CHIP. The state's plan suggests that PHS will modify its age guideline from children at birth through age 21 to children ages 18 through 21. Caring Program (CP)[35] participants were also encouraged to enroll in CHIP; one month before Phase I began, the program sent families a letter informing them about CHIP and providing an application and prepaid return-mail envelope. CP families who completed applications mailed them back to the CP, who then hand-delivered the applications to the CHIP office. Approximately half of CP's 900 enrollees applied for CHIP through this effort.

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[34] Health Care Financing Administration: *National Summary of Medicaid Managed Care Programs – June 30, 1998*. Baltimore, MD: Author, 1999.

[35] Since CHIP provides comprehensive health insurance to the same eligibility group, the Caring Program's Board of Directors terminated coverage effective March 31st of this year. The program decided against changing its eligibility guidelines since they anticipated fund-raising difficulties for higher income children. Mountain State BC/BS, administrator for CP, remains involved in children's health insurance as the administrator for Phase II under the PEIA. CP is currently evaluating its next steps.

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Rural Outreach Strategies

Administrative Simplification

Statewide administrative simplification efforts to increase enrollment include a guarantee of one year of continuous eligibility, coordination of CHIP with other public programs, adoption of mail-in applications (in-person interviews are not required for either Phase), and adoption of an automated eligibility system. Phase I children have encountered difficulties with one-year continuous eligibility. Parents experienced with other DHHR programs routinely report changes to their income or living situation. These changes have triggered a redetermination of eligibility, resulting in loss of coverage or coverage through regular Medicaid, which does not offer one-year continuous eligibility.

Applications for free or reduced lunch or textbooks allow individuals to request information on Medicaid coverage and will be edited to include a section on CHIP. Both phases of CHIP are represented on one application (this application does not include traditional Medicaid). CHIP information and applications have been distributed to the public schools statewide. Applications include a postage-paid envelope. Though the state has eliminated in-person interviews for CHIP, Medicaid still require a face-to-face interview. The DHHR has an automated eligibility system called RAPIDS (Recipient Automated Payment and Information Data System) that can evaluate CHIP and Medicaid eligibility. At the start of Phase II, RAPIDS triggered an application form and explanatory letter to applicants denied Phase I coverage prior to the beginning of Phase II, encouraging them to apply.

CHIP Information and Application Assistance

The state has begun several activities to disseminate CHIP information at the local level. A toll-free telephone line, "Family Matters" (1-888-WV-FAMILY), provides information and referral about various forms of assistance, including Medicaid and CHIP, 24 hours a day. West Virginia has enlisted the support of RWJF grantee recipients to target specific local audiences to increase enrollment.

The state had initially intended to disseminate CHIP information through school report cards; however, not all county school superintendents agreed to this effort. In its place, the state's CHIP office established contacts in each county to whom they have sent informational mailings on the program. These materials include a handbook that presents a unified approach for community outreach and application assistance. County contacts include school principles, school teachers, school nurses, churches, day care centers, Starting Points Centers,[36] a provider newsletter, the Energy Express Program,[37] primary care physicians, state nurses, and other providers. These contacts, in turn, have initiated their own efforts, such as making presentations at aging centers to increase awareness

[36] Starting Points is a day care center similar in design to Head Start programs. Starting Points is an initiative of the Carnegie Corporation of New York.

[37] During the summer months, the Energy Express Program provides tutoring in reading to low-income children through college student volunteers.

among grandparents. Energy Express volunteers have assisted families with applications and helped target participants' siblings. The state's Faculty Senate program provides a monthly format for disseminating information on state educational policy as well as discussion of teachers' needs and concerns. The state wrote letters to the coordinators of this program asking them to disseminate information on CHIP to their colleagues to help identify potentially eligible students.

In a joint venture with the state Department of Education, the CHIP office is pursuing a special CHIP issue of "Newspapers in Education." This program provides a specialized newspaper format for children of all ages with various topics that teachers can use for classroom instruction. The special issue will focus on children's health, particularly use of preventive care. The issue will include a CHIP application and an explanation of the program.

CHIP applications and assistance in completing the application are available at medical care sites and other places families frequent. The state's plan indicates that CHIP applications will be available in rural health clinics, hospitals, primary care centers, physicians and dentists' offices, schools, child care centers, FQHCs, willing businesses employing parents with eligible children, Starting Point Centers, Family Resource Networks, libraries and at local DHHR offices. The state office is considering supplying CHIP information to family courthouses so that families going through divorce proceedings are reminded of the potential lack of health coverage for their children. Outstationed eligibility workers operate in several major hospitals through an arrangement with the state's Hospital Association. Trained eligibility workers also take applications through a laptop computer at selected sites, such as rural health clinics, schools, pediatric clinics, Primary Care Centers, and FQHCs.

The West Virginia Healthy Kids Coalition,[38] a Covering Kids grantee, plans to work at the community level to achieve statewide goals. The coalition's nine coordinators conduct grassroots outreach across two to three counties each. The Coalition plans to target children in rural areas with their community outreach efforts and will also target minority children in inner-city schools and children of migrant workers in the Eastern Panhandle. The state CHIP office feels it has been difficult to coordinate the efforts of the Coalition with those of the state.

Outreach Strategies Specific to Rural Areas

While our state contacts have not undertaken outreach strategies designed to target enrollment among children living in rural areas, we found several examples occurring through personal initiative, outreach funding, and the concern of advocates.

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[38] The Coalition includes the state's Council on Churches, Primary Care Association, Hospital Association, Community Development Outreach Activities, the Governor's Cabinet on Children and Families, the University System, the Coalition for West Virginia Children, and the Community Council of Kanawha Valley.

The state CHIP office identified the outreach efforts of one physician in rural Wyoming County. The physician has increased CHIP enrollment through her own efforts to inform and enroll her patients in the program. Wyoming County led the state in enrollment of children through age five as of June 1999.

One of the state's three Covering Kids pilot projects targets the rural counties of Nicholas, Webster, and Braxton. The project's CHIP coordinator had been employed for one month at the time of our interview, but had already conducted outreach at several fairs and festivals during the spring. Noting that outreach activities should coordinate with the activities in the community of the target population, the project will focus outreach activities on schools in the fall. When families take applications to complete at home, the coordinator asks if she may call the family to see if they need assistance or just to remind them to return the application. Various community organizations (such as schools, day care providers, and Healthy Start programs) are involved in the three-county coalition. Coalition members distribute information to the families they serve and also assist with applications. The local coalition is knowledgeable of appropriate activities in their communities for outreach efforts and has an established relationship with the people they serve. Our contact noted that information provided by the state, such as the outreach handbook, has been very helpful.

While the state is not aware of any problems in enrolling rural children, officials understand that having an insurance card does not mean children receive care. One of the strategic goals for both Phases is to assure that children enrolled under Title XXI know when to seek health care and obtain the necessary transportation. They are considering ways of educating families about the use preventive and primary care and innovative solutions to transportation problems in rural areas (e.g., offering school bus rides to parents so they may attend children's school-based health center appointments). A Covering Kids outreach coordinator identified time constraints and inconvenience of various CHIP promotional activities as a barrier to enrollment for urban and rural working families and suggested that promotional activities be held during non-traditional hours.

Our Caring Program contact reflected on his experiences in rural areas and identified a good working relationship with rural health clinics (RHCs) as key to CP success and a possible approach for CHIP. A number of RHCs had been active partners in CP enrollment since they were able to identify which children were uninsured and could provide application assistance. Not only did clinic involvement boost CP enrollment in rural areas, but it provided a source of payment for the clinics.

Barriers to Effective Outreach

One respondent felt that CHIP would be more successful if the entire program was a separate, non-Medicaid expansion. This person felt that built-in conflicts between the two programs, such as slightly different benefit packages, application requirements, and association of Medicaid with welfare by some families, compromised program

potential. Medicaid caseworkers were thought to be overworked even before Phase I was implemented.

Enrollment

As of June 11, 1999, 3,818 children had been insured through CHIP and 1,200 (31 percent) of these were eligible for traditional Medicaid. Though the state does not specify enrollment goals, it anticipates that 1,741 children are eligible under Phase I and 22,901 under Phase II. Based on these figures, Phase I covers 58 percent of eligible children while Phase II covers 15 percent, as shown in Table 9. Our selected rural counties have had experienced a range of success in keeping pace with state enrollment in both phases of the program. While Braxton, McDowell, and Upshur lag behind the state, the other two counties are near or have exceeded the state in percent change over the three-month time period.

Table 9
West Virginia CHIP Enrollment in Five Counties, June - August 1999

PHASE I Counties	**June**	**August**	**Phase I Percent Change**	**Phase I and II Percent Change**
Braxton	12	14	16.7%	60%
Harrison	28	34	21.4	106
McDowell	16	19	18.8	53
Preston	29	39	34.5	88
Upshur	11	12	9.1	58
WEST VIRGINIA	808	1,002	24.0	71
PHASE II Counties	**June**	**August**	**Phase II Percent Change**	**Phase I and II Percent Change**
Braxton	23	42	82.6	60%
Harrison	57	141	147.4	106
McDowell	71	114	60.6	53
Preston	46	102	121.7	88
Upshur	37	64	73.0	58
WEST VIRGINIA	1,810	3,470	91.7	71

Source: West Virginia Children's Health Insurance Program Board

Rural Provider Participation Issues

The expansion of the children's health insurance program in West Virginia has had varying impacts on physicians. Most physicians we spoke with from our selected rural counties knew little about the expansion and thought they had only one or two CHIP patients. Generally, physicians were unaware of the type of coverage their patients have since their billing staffs handle payment. A pediatrician who advises the state Academy

of Pediatrics on CHIP issues did not feel there were significant problems. Among members of this society there were few complaints, with most pediatricians looking forward to improvements in coverage. A pediatrician in Preston County who does see a number of CHIP patients felt the program meets a great need of children and is better than the limited coverage and reimbursement under the Pediatric Health Services program. Neither the state medical society nor the state Academy of Pediatrics had any strong feelings about the expansion of CHIP, but the number of enrolled patients seen by physicians is not large.

In discussions with the West Virginia Dental Association, we heard that dentists in rural areas of West Virginia actively participate in Medicaid and therefore actively participate in Phase I. Approximately 400 of the state's 900 dentists participate in Medicaid. The Association also felt that, since reimbursement is the same, those dentists who participate in Medicaid are likely to participate in Phase II. However, PEIA experienced delays in operationalizing the dental benefit since they did not previously offer this benefit. Children covered under Phase II did not begin receiving dental services until July 1999. It is anticipated that the legislature will add x-rays as covered services to the dental plan for Phase II.

Through interviews and review of state documents, we identify outreach strategies in use and those that have helped to enroll children in rural areas, determine whether CHIP has improved insurance coverage of children in rural areas, and examine issues related to provider participation in rural areas. Although limited to information from five states and 25 rural counties, our findings may be of interest to state policymakers who are implementing CHIP programs and policymakers concerned with insurance and access to care in rural areas. Our study states represent a mixture of separate, Medicaid, and combination strategies, which we hope offer a useful range of experience for other states.

Rural Outreach Strategies

Coordination with Public Programs and Administrative Simplification

Our five states each adopted approaches to coordinate their CHIP program with other public programs and to simplify their application process. Three states with separate, non-Medicaid programs chose to coordinate their CHIP programs with Medicaid through a joint application and eligibility determination process, while others coordinated their outreach activities with other public programs. The five study states also elected to simplify the enrollment process by allowing applicants to self-report their income. Each offered one-year of guaranteed program eligibility. Colorado and Oklahoma simplified the renewal process by sending families renewal applications in advance of the end of their eligibility. With the exception of Colorado, the study states had not taken advantage of presumptive eligibility or satellite eligibility determination sites. We have heard through discussion with the National Association for Community Health Centers that, as a group, community health centers are eager to assist in eligibility determination. From our five state review, we find that the study states have actively enlisted providers into offering information and application assistance, but do not generally use local providers as sites for eligibility determination. States distribute information and provide application assistance through various public agencies, such as schools, libraries, and clinics, as well as through hotlines, internet sites, and during health care visits.

Outreach to Rural Areas

Our states have recruited an array of individuals to contribute to their outreach efforts, including parents, grandparents, public health nurses, high school athletic directors, employers, and volunteers. They have also been assisted by various organizations including community health centers and WIC. A major theme of our interviews is that outreach workers conduct their activities at the places families frequent. Outreach was conducted at community events such as school registrations, high school

sporting events, fairs and festivals, religious services, and health care visits, and at created events, such as health fairs at department stores. Application assistance is another important way to help families provide accurate and complete eligibility information. The reliance on schools for outreach activities seems well placed. Most uninsured Medicaid eligible children, 54 percent, are under age six, but 42 percent of these children have a school age sibling, aged six to 17.[39]

The RWJ Covering Kids program is an important source of funding for outreach in rural areas. In our previous report, we found few examples of outreach activities tailored specifically to the needs of rural communities. Now we find multiple activities underway in our selected counties. However, even when a Covering Kids grantee is a rural provider, as in Kansas and Oklahoma, a host of issues remain, complicating and impeding rural provider participation in CHIP. In a Kansas pilot project run by a CHC, the Center itself does not participate in HealthWave because it is concerned about disrupting existing referral patterns under the network requirements of managed care. In an Oklahoma pilot project run from a community hospital, hospital providers and recipients have expressed a negative attitude towards SoonerCare because it is a Medicaid and government sponsored program.

Barriers to Effective Outreach

Several barriers to effective outreach were common across our states. We heard repeatedly that some potential CHIP recipients associated the program with welfare and indeed this negative association has been documented among Medicaid beneficiaries elsewhere.[40] We also found that potential eligibles are unaware that they may qualify under the revised eligibility standards, do not understand the benefits of health insurance, and often have other urgent needs that take precedence over health insurance. Public charge was a significant deterrent to enrollment of legal immigrants in Oklahoma. This may continue to be an issue even with federal clarification, since the literature has documented public charge as a profound barrier to enrollment.

In states with cost-sharing requirements (Colorado, Kansas, and Pennsylvania), some respondents expressed concerns that premiums and copayments could discourage potentially eligible families from applying. While we heard of no objective evidence documenting this occurrence, a recent study found that low-income, working families who qualify for private coverage might not be able to take advantage of the insurance because of the monthly premium.[41]

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[39] GAO, 1998.

[40] Smith VK, Lovell RG, Peterson KA, O'Brien MJ: *The Dynamics of Current Medicaid Enrollment Changes: Insights from Focus Groups of State Human Services Administrators, Medicaid Eligibility Specialists and Welfare Agency Analysts*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 1998.

[41] Children's Defense Fund: *The Waiting Game: Children's Defense Fund Focus Group Report on the Children's Health Insurance Program and Medicaid*. Washington, DC: Author, 1999.

Enrollment

The information we received from each state regarding enrollment by county varied in content, limiting our ability to comment on success in enrolling children from rural areas. West Virginia provided counts of enrollment for each county in June, whereas the ratio of applicants to enrollees and monthly enrollment was available from Colorado. States also provided data specific to their implementation dates and availability. As a result, our data are not directly comparable across states. We can, however, make a few general comments. Our five states had enrolled well over 10,000 children each, excepting West Virginia with 3,000 new enrollees. Each state appeared to be progressing toward a significant increase in health insurance coverage among the targeted populations. Colorado, Oklahoma, and Pennsylvania covered a significant portion of their uninsured children living in rural areas. In Oklahoma and Pennsylvania, the rural study counties had done nearly as well or better than the state overall in increasing coverage. Enrollment success in Kansas and West Virginia was more modest; in some counties, enrollment over several months kept pace or exceeded the change in overall state enrollment, while other counties lagged behind the state. Medicaid enrollment had increased in Kansas, Oklahoma, and West Virginia, the only states that were able to supply that information. In Kansas, Medicaid enrollment had kept pace with HealthWave, each with approximately 11,000 new enrollees, while in Oklahoma, 27,000 were newly enrolled in traditional Medicaid.

As preparation of this report was nearing completion, we obtained follow-up data for Kansas, Pennsylvania, and West Virginia. This data enabled us to examine change in enrollment for urban and rural counties across several months. Using a multivariate model controlling for baseline enrollment and income, our analysis indicated that the percent change in enrollment in rural counties is no different from urban counties. This preliminary evidence indicates that rural areas are proceeding with the same momentum in enrollment as urban areas. Enrollment data has emerged as an issue of great importance in determining programmatic success, as evidenced by the recent concerns of several Senators and the President on the lack of complete data for all states.[42]

Rural Provider Participation Issues

Most states seemed to have significant difficulties attracting providers to their programs and addressing provider concerns. Though providers often welcomed CHIP as a means to increase children's insurance coverage, providers' concerns about the program – reliance on managed care, low levels of reimbursement, and bureaucratic burden – have effected their willingness to participate. However, regardless of the extent of provider dissatisfaction, we found many physicians in the study counties (in Kansas, Pennsylvania, and West Virginia) who expressed support for CHIP and the consequent improvements in access to care for enrollees.

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[42] Senators, President lack CHIP numbers as recruitment efforts set to increase. *Community Health Funding Report*. No. 99-15, August 17, 1999.

While we repeatedly heard of physician aversion to managed care, some states are flexible in their contracting practices with rural physicians. In Colorado and Kansas, program administrators were willing to or had negotiated contracts with rural providers that are different from contracts with other providers. However, the Kansas program's inability to enroll specialists in its provider network adversely affected enrollment of primary care providers in the rural southwest area of the state.

Inadequate reimbursement was a singular complaint among providers in rural areas. For several physicians, CHIP and Medicaid reimbursement levels do not cover the cost of well-child care in Oklahoma and Pennsylvania. In Oklahoma, recipients use the Health Department for their well-child care and immunizations because of a lack of participating providers. In Colorado and Oklahoma delayed payments and patients re-assigned to other providers resulted in a great deal of frustration with program administration. Where separate programs exist, different providers may serve families when providers participate only in CHIP or Medicaid (in Colorado and Pennsylvania).

While all of our states cover dental services (except for West Virginia's Phase II), we found evidence from some states of difficulties in securing dentists' participation. Oklahoma has witnessed a severe drop in the number of dentists participating in Medicaid over the past 10 years and is expected to be out of compliance with EPSDT dental requirements in an upcoming report from HCFA. In Kansas, a child's enrollment in either HealthWave or Medicaid appears to affect the accessibility of dental services, since HealthWave has been much more successful in attracting providers primarily as the result of higher reimbursement rates than Medicaid.

An Oklahoma physician noted that CHIP creates an increase in demand for medical care, while the capacity for services remains unchanged. While past efforts to cover uninsured children have not fully enrolled the intended population, CHIP recognizes this challenge with formal requirements for outreach as well as supplemental efforts through the RWJF. Ultimately, the test of outreach efforts is whether they improve *access* to care.[43] A preliminary study suggests that CHIP enrollment will double the use of physician services.[44] However, our evidence indicates that there may be access problems in some rural areas. As we have found, physicians do not automatically participate in CHIP programs, even non-Medicaid ones. We found a shortage of dental providers willing to accept Medicaid patients, noted even in the popular press.[45]

In conclusion, we find states more aggressive in outreach and enrollment activities in rural areas under CHIP than in children's insurance programs prior to CHIP. The RWJF Covering Kids initiative is an important funding source for many of the rural outreach activities in our study states. States appear to be concerned with enrolling hard-

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[43] DeChiara, M, Wolff T: Topics for our times: if we have the money, why is it so hard? *American Journal of Public Health*. 88:1300-1302, 1998.

[44] Long SH, Marquis MS: Geographic variation in physician visits for uninsured children: the role of the safety net. *Journal of the American Medical Association*. 281(21):2035-2040, 1999.

[45] Goldberg C: Poor children with bad teeth have trouble finding dentists. *The New York Times*. A1:June 26, 1999.

to-reach populations and have identified children in rural areas as part of this group. However, we remain concerned that children enrolled in CHIP may experience limited access to care in rural areas. Many providers have strong, positive commitments to CHIP's goals, yet do not participate or are dissatisfied with CHIP or Medicaid because of their objections to managed care, administrative burdens, and low levels of reimbursement. Further research is needed to determine whether CHIP enrollment will improve access to care. Other questions to address in the future include: Will the provider capacity of rural areas adequately support services to CHIP children? Will enrollment in rural areas keep pace with that of enrollment in urban areas? How can resistance to government-sponsored programs and welfare stigma be overcome? Will states that expand their Medicaid programs capitalize on the efficiencies of the existing system or will separate approaches, possibly based more on private sector models, have greater success in enrollment? Will children fair well under managed care versus fee-for-service arrangements? We are hopeful that we will see further improvements in outreach and enrollment of children in rural areas as implementation efforts continue.